

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, March 20, 2012 at the hour of 12:00 P.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Ansell called the meeting to order.

Present: Chairman David Ansell, MD, MPH and Directors Hon. Jerry Butler and Luis Muñoz, MD, MPH
(3)

Absent: None (0)

Additional attendees and/or presenters were:

Faran Bokhari, MD – John H. Stroger, Jr. Hospital
of Cook County
Barbara Farrell – System Director of Quality and
Patient Safety
Claudia Fegan, MD – John H. Stroger, Jr. Hospital
of Cook County
David Goldberg, MD – John H. Stroger, Jr. Hospital
of Cook County
Terry Mason, MD – System Chief Medical Officer
Linda Rae Murray, MD – Cook County Department
of Public Health

Ashlesha Patel, MD – John H. Stroger, Jr. Hospital
of Cook County
Ram Raju, MD, MBA, FACS, FACHE – Chief
Executive Officer
Elizabeth Reidy – System General Counsel
Tanda Russell – System Interim Chief Nursing
Officer
Deborah Santana – Secretary to the Board
Carol Schneider – System Chief Operating Officer
Pierre Wakim, MD – Provident Hospital of Cook
County

II. Public Speakers

Chairman Ansell asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore Concerned Citizen

III. Report from System Chief Medical Officer

Update on the Get Yourself Tested Initiative

Dr. Terry Mason, System Chief Medical Officer, introduced Dr. Ashlesha Patel, of John H. Stroger, Jr. Hospital of Cook County; Dr. Patel provided an update on the activities relating to the Get Yourself Tested (GYT) initiatives (Attachment #1). The Committee reviewed and discussed the information.

Dr. Mason stated that one of the goals previously discussed was to partner with the City of Chicago's Department of Public Health to implement a model similar to that used by the City of Philadelphia; under this type of model, screenings for sexually transmitted diseases would be done for all of the students in the high schools. He stated that this type of program needs to be done and needs to be funded every year. He added that it should be started in the high schools; however, he noted that there is data that suggests that perhaps middle school would also be a good place to implement such a program. When this type of program was previously discussed, the funding for such a program, just for the City of Chicago, was estimated to cost approximately \$3 million per year; Dr. Mason indicated that a program such as this is not cheap, but it is a step in the right direction.

III. Report from System Chief Medical Officer (continued)

Director Butler inquired whether this is an area in which other hospitals could participate. Dr. Mason responded affirmatively. He stated that, in the past, there has been some interest in participation by other hospitals. He added that support that has been received is episodic; this requires a multi-year effort. Dr. Ansell noted that Rush is in three school-based clinics; that could be a commitment that Rush could make around those institutions to do a screening of the students; he added that, as a public health measure, it would be worthwhile pursuing.

Dr. Linda Rae Murray, Chief Medical Officer of the Cook County Department of Public Health, noted that reducing sexually transmitted diseases in young people is one of the health priorities of the Cook County Department of Public Health; she added that small amounts of funding have been received for the purpose of focusing on enhanced surveillance, which involves tracking down a case and tracking down a network. Chairman Ansell suggested that Dr. Mason, Dr. Patel and Dr. Murray further review the subject.

Update on North Atlantic Treaty Organization (NATO) Summit Preparations

Dr. Mason provided an update on NATO Summit preparations. He stated that the incident action plan for Stroger Hospital is being prepared. There are a couple of drills that will take place; he added that one of the issues that is currently being reviewed is a potential use for Provident Hospital for surgery capacity. In addition to that, from a public health point of view, there will be an increased surveillance for infectious diseases.

Update on Care Coordination Subcommittee for Section 1115 Waiver

Dr. Mason provided an update on the activities of the Care Coordination Subcommittee for the Section 1115 Waiver. He stated that the Subcommittee is looking at the entire organization, to review opportunities for enhanced or increased capacity, to be able to better deal with the nearly one hundred thousand patients that the System hopes to enroll. He stated that Frank Borgers, who is representing all of the unions with the exception of the National Nurses Organizing Committee (NNOC), and Emilie Junge, who is representing the SEIU Doctors Council, have been involved as the System has moved through this preparation.

A. Update on transition activities for Oak Forest Health Center

Carol Schneider, System Chief Operating Officer, provided the update on the transition activities for the Oak Forest Health Center. She stated that an Open House event was held at the Oak Forest Campus last Thursday afternoon; guests invited to the event included elected officials, representatives from area hospitals, employees and subcommittee members who have been working on the project. She stated that blueprint drawings were presented; she added that they are very basic and are in draft form. Draft forms of all of the floors of the E Building were presented as they are envisioned going forward, based on the availability of future capital. Also presented were the guiding principles regarding the patient care plans for the campus, and the initial plans for the Imaging Center. Ms. Schneider stated that this information will be provided in a presentation at the next System Board Meeting on March 29th.

IV. Report from System Interim Chief Nursing Officer

Tanda Russell, System Interim Chief Nursing Officer, provided an update on the subject of bed closures at Stroger Hospital. As reported to the Committee in January, a significant number of retirements that occurred in the month of December impacted the nursing units; as a result of this, twenty-four to twenty-eight beds in the Medical-Surgical units were closed in order to provide safe staffing levels. It was reported at the February Committee Meeting that fourteen of the twenty-eight beds were re-opened. Ms. Russell provided additional information on the continuing efforts to recruit nurses; she added that twelve beds currently remain closed.

Ms. Russell noted that at the February Committee meeting, a request was made for the development of a dashboard for nurse staffing and nursing hours standards; she stated that she is working on the development of this with Barbara Farrell, System Director of Quality and Patient Safety.

V. Report from System Director of Quality and Patient Safety

Barbara Farrell, System Director of Quality and Patient Safety, presented her report. She stated that last week, a bill was sent to the Illinois House Health Care Availability and Accessibility Committee; this bill (HB3772) is proposing an amendment to revise the existing listing of serious events under the 2005 Adverse Events Health Care law. She stated that she will continue to provide updates as further information is received.

Ms. Farrell stated that one of the goals related to Quality and Patient Safety was to add a System-wide nursing quality council; activity on this subject began in January. She stated that this has representation from all of the affiliates; the goal is to bring more substantive quality-driven initiatives from the front-line nursing staff.

A. Quality report from John H. Stroger, Jr. Hospital of Cook County

Dr. Claudia Fegan, Chief Medical Officer of the John H. Stroger Hospital of Cook County, stated that presentations from the Department of Trauma and Burns and the Department of Critical Care will be provided in this report. She provided information on the following three quality-related issues, on which she and her staff have been working: infusion center – there is an issue with staffing and a large volume of patients; management of patients with alcohol withdrawal – she stated that the problem is that there needs to be more rigor in treating it as another diagnosis, rather than just a symptom; and patients with significant complications of anticoagulation therapy –there is a problem with getting patients in to be seen when they are in their most vulnerable period, which is the first ninety days of therapy. She provided information on how these issues were reviewed, and what corrective measures have been taken. Chairman Ansell noted that for issues such as these, when improvement is achieved, the next year's quality improvement plan will reflect this in processes implemented.

Dr. Faran Bokhari, Chair of the Department of Trauma and Burns, presented the Trauma/Burn Quality Assurance 2011 Report (Attachment #2). Included in the presentation was information on the following subjects: Encounters by Injury Type; Trauma Dashboard 2011; Burn Center Data 2011; and Future Directions.

Dr. Fegan presented the report from the Department of Critical Care (included in Attachment #2). Included in the presentation was information on the following subjects: Critical Care Mortality Data; Example: Medical Intensive Care Unit (MICU) Mortality Data 2011; Improving Physician, Nurse, Therapist Communications – Daily Rounds Sheets; Daily Rounds Sheets Compliance; and Future Plans for Critical Care.

VI. Recommendations, Discussion/Information Item**A. Reports from the Medical Staff Executive Committees**

- i. Provident Hospital of Cook County**
- ii. John H. Stroger, Jr. Hospital of Cook County**

Dr. Pierre Wakim, President of the Executive Medical Staff of Provident Hospital of Cook County, presented a report on the following subjects: Report on Task Force-Increase OP Surgical Cases (Gynecology); Virtual Bed Update; Next Provident Task Force - Gastroenterology Backlog; and Provident Hospital's Role in System Waiver Approval - Inpatient Beds.

Dr. David Goldberg, President of the Executive Medical Staff of John H. Stroger, Jr. Hospital of Cook County, presented his report. He stated that the Executive Medical Staff (EMS) meeting was held on March 13th; at this meeting, information technology infrastructure hardware-related issues were discussed. Dan Howard, System Chief Information Officer, was present at the meeting; this discussion was helpful for EMS and for Mr. Howard and his team to understand some of the issues.

Dr. Mason noted that Stroger Hospital recently celebrated the 75th Anniversary of the founding of the Blood Bank by Dr. Bernard Fantus; a number of activities were held to honor this important event.

VII. Action Items**A. Minutes of the Quality and Patient Safety Committee Meeting, February 21, 2012**

Director Butler, seconded by Chairman Ansell, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of February 21, 2012. THE MOTION CARRIED UNANIMOUSLY.

B. Approval of 2012 Quality Improvement Plans for the following:

- i. John H. Stroger, Jr. Hospital of Cook County (Attachment #3)**
- ii. Provident Hospital of Cook County (Attachment #4)**
- iii. Ambulatory and Community Health Network of Cook County (ACHN) (Attachment #5)**

Ms. Farrell presented the three quality plans for the Committee's consideration and approval. She stated that there are measures in each of the plans; however, the measures are separated out in the plan for ACHN, because ACHN is now in the phase of meeting meaningful use requirements, and is also going through an electronic records upgrade. ACHN is trying to align all of those pieces with what is required from the Federal government to what is required from the entities with whom it partners.

Chairman Ansell stated that in the future, the quality plans should have a similar format across the entities. He added that it would be helpful for him to see what is being worked on and why for each of the areas.

Director Butler, seconded by Chairman Ansell, moved to approve the three (3) 2012 Quality Improvement Plans presented. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections VI, VII and VIII

VIII. Closed Session Item

A. Medical Staff Appointments/Re-appointments/Changes (Attachment #6)

Note: the Committee did not recess the regular session and convene into closed session.

Director Butler, seconded by Chairman Ansell, moved to approve the Medical Staff Appointments/Re-appointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

IX. Adjourn

As the agenda was exhausted, Chairman Ansell declared that the meeting was ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
David Ansell, MD, MPH, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #1

GET YOURSELF TESTED (GYT) INITIATIVE

2012 GYT Campaign SYSTEM-WIDE



Terry Mason, M.D., FACS,
System Chief Medical Officer
Cook County Health & Hospitals System



BACKGROUND

- **The CDC estimated - approximately 19 million new STD infections each year.¹**
- **Cost: 16.4 billion annually & cost individuals even more.**
- **Regardless of race or gender - sexually active adolescents (15-24 years old).**

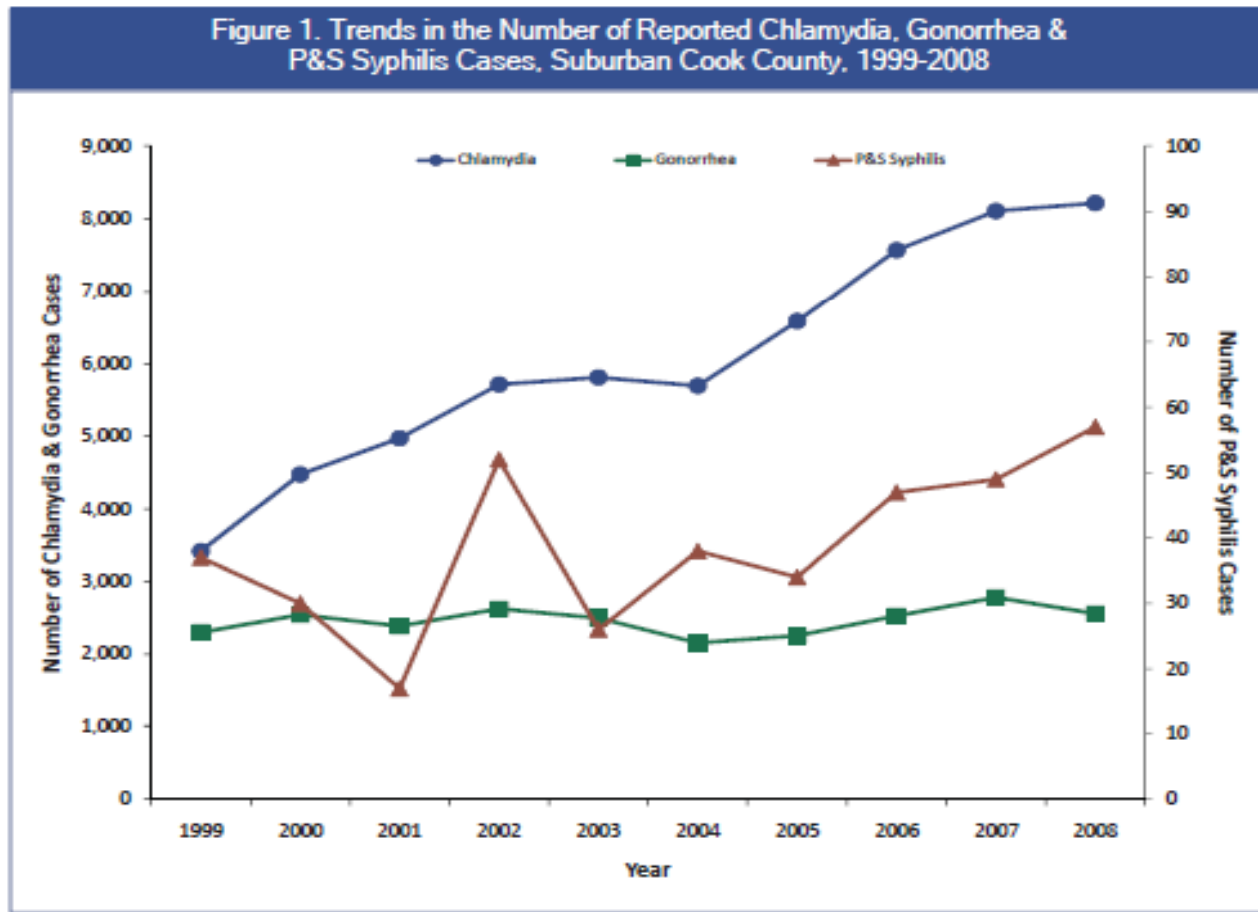
1. Weinstock H, et al. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health* 2004;36(1):6-10.

WHY?



Suburban Cook County

1999-2008



Sexually Transmitted Infections Surveillance Report, 2006-2008

Cook County Department of Public Health

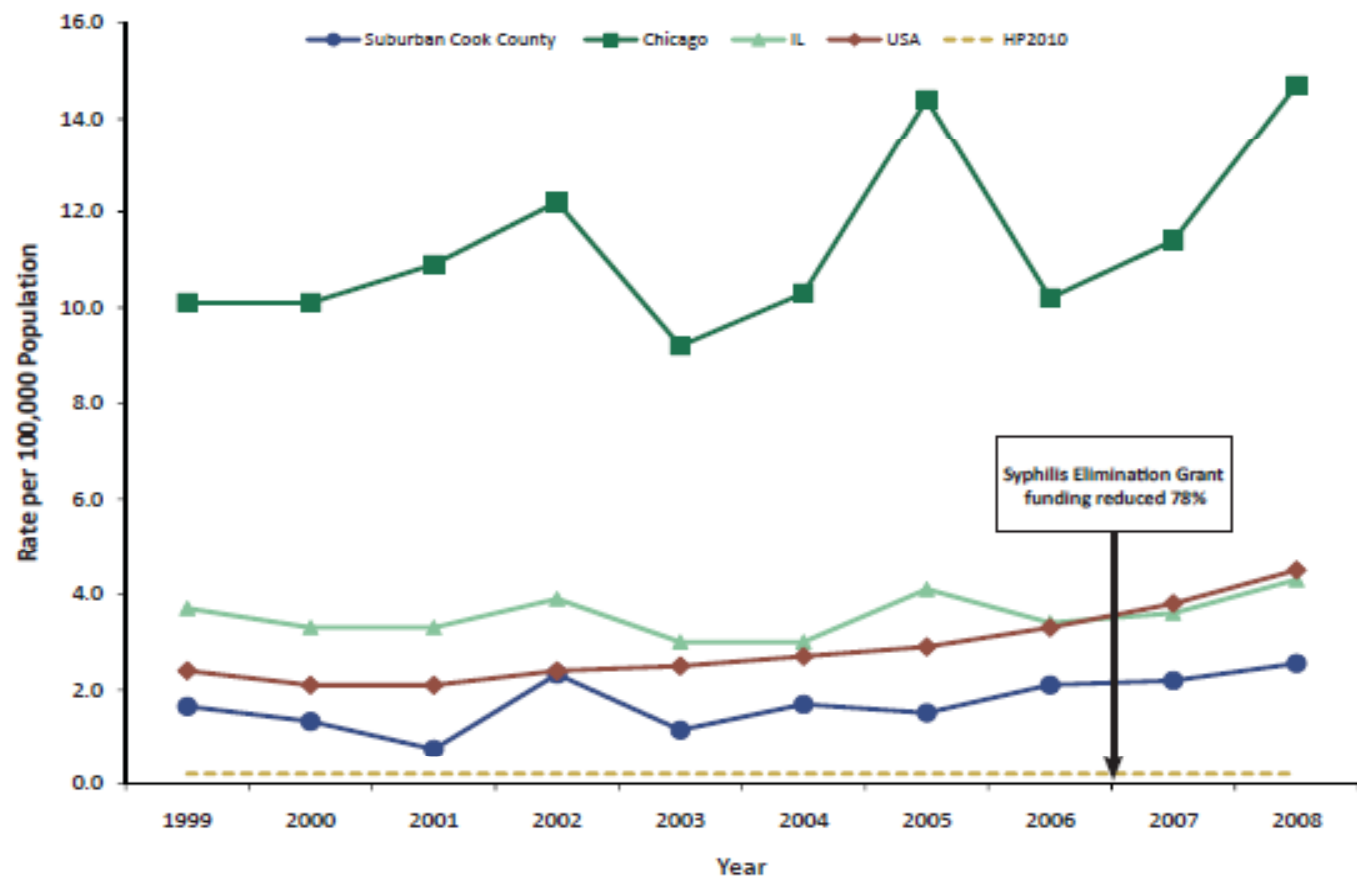


P&S Syphilis Rates

Sexually Transmitted Infections Surveillance Report, 2006-2008

Cook County Department of Public Health

Figure 12. Trends in Reported P&S Syphilis Rates (per 100,000 population) for Selected Public Health Jurisdictions, 1999-2008



WHY?

Table 1. Chlamydia, gonorrhea, and primary and secondary syphilis - Counties and independent cities ranked by number of reported cases: United States, 2008

	Chlamydia	Gonorrhea	Primary and Secondary Syphilis
1	Los Angeles County, CA 46,707 cases 472.8/100,000 population	Cook County, IL 13,227 cases 250.3/100,000 population	Los Angeles County, CA 822 cases 8.3/100,000 population
2	Cook County, IL 34,252 cases 648.2/100,000 population	Wayne County, MI 9,801 cases 457.5/100,000 population	New York County, NY 491 cases 30.3/100,000 population
3	Wayne County, MI 19,218 cases 968.1/100,000 population	Los Angeles County, CA 8,959 cases 90.7/100,000 population	Cook County, IL 488 cases 9.2/100,000 population
U.S. Rate	401.3/100,000 population	111.6/100,000 population	4.5/100,000 population
HP2010 Target	138.0/100,000	19.0/100,000	0.2/100,000

City of Chicago Department of Public Health

"Don't get fooled this April. Test yourself."

April is "Get Yourself Tested" month. Get tested at any CCHHS facility for free and get the 411 on STD's.

GET YOURSELF TALKING
Get tested today at your nearest ACHN Clinic

GYT

GET YOURSELF TESTED
COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

IT'S TIME

GET YOURSELF TESTED
GYTNOW.ORG

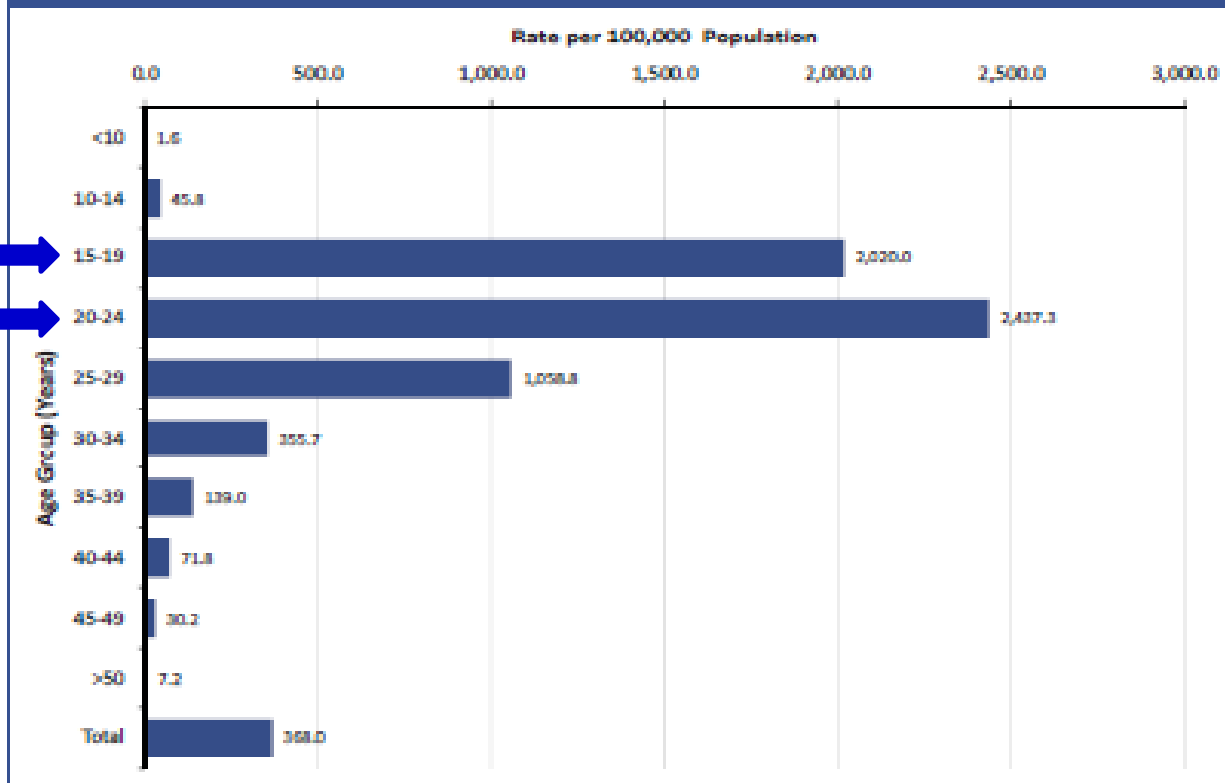
COOK COUNTY HEALTH & HOSPITALS SYSTEM

Chlamydia Rates

Aged Group (15-24)

Sexually Transmitted Infections Surveillance Report, 2006-2008

Figure 3. Chlamydia Rates (per 100,000 population) by Age Groups. Suburban Cook County, 2008

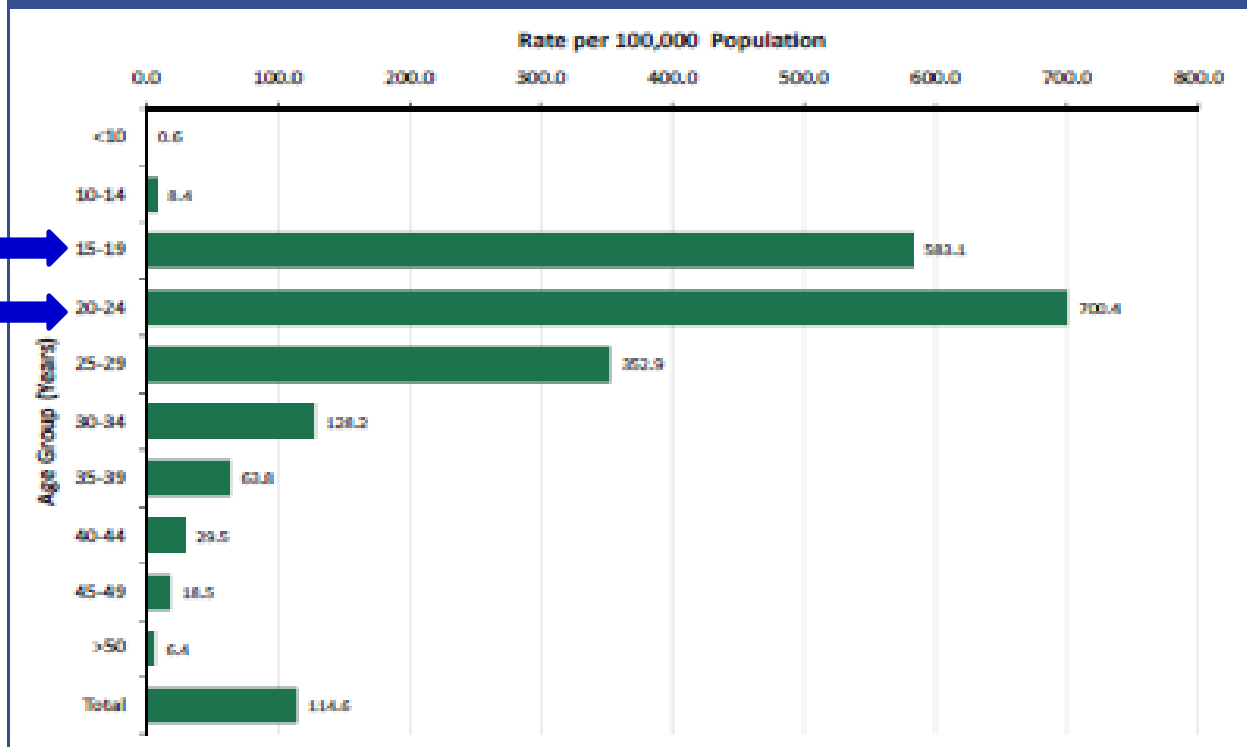


Gonorrhea Rates

Aged Group (15-24)

Sexually Transmitted Infections Surveillance Report, 2006-2008

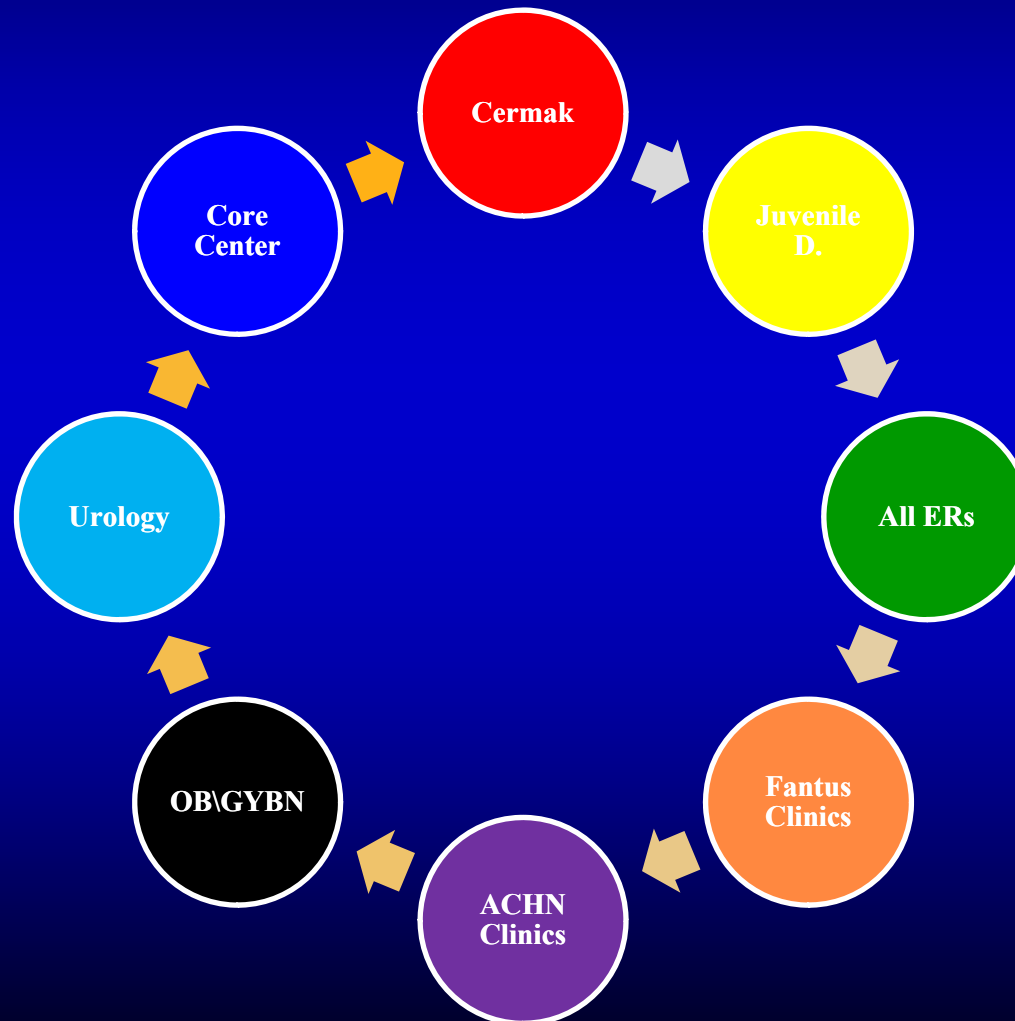
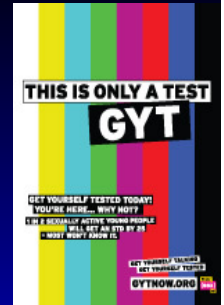
Figure 8. Gonorrhea Rates (per 100,000 population) by Age Groups, Suburban Cook County, 2008



WHAT?



CCHHS Internal Departments and Clinics 2011 STI Initiative



GYT Campaign SYSTEM-WIDE



Inform young people about STIs.

- **Encourages normalize testing.**
- **Connect them – STI testing centers.**
- **Create a youthful and empowering social movement to get screen.**



Fast Track STI Screening Services

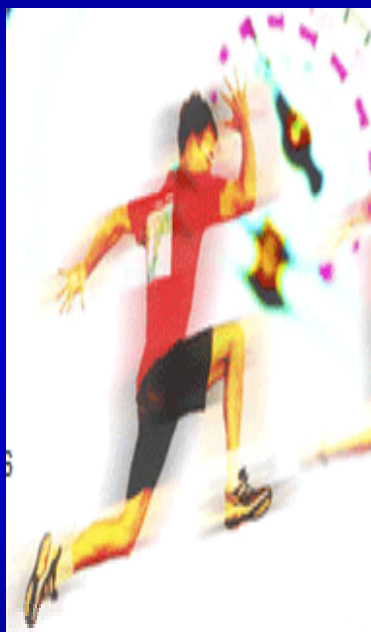
WHERE?



Welcome to Family Planning Fast Track STI Screening Clinic

The Fast Track STI Screening Clinic is the point of entry for our patients to have access into the Cook County Health and Hospitals System.

Monday – Thursday Open 8:00 am to 4:00 pm.



Services Provided

Quick registration

Chlamydia Testing

Gonorrhea Testing

Rapid HIV Testing (Optional)

Syphilis Testing (Optional)

Patient STI Education

STI Treatment

Core Center Referrals

(The physician test order, specimen collection, lab testing processing, results, and education are all part of the service).

1901 West Harrison Street, 1st floor Chicago, Illinois 60612

Phone Number: 312-864-49787

Fast Track STI Screening Services

- April 2012, “Fast Track STI Services” (FTS).
- Alternative to long wait lines & access barriers.
- Eligibility: 15-24 years old with or without STI symptoms.



Welcome to Family Planning Fast Track STI Screening Clinic

Family Planning Clinic

Dr. Patel (Medical Director) & Mrs. Smith (Clinic Administrator)



- **Clients will have the following: register, screen, treatment, education & follow-up.**
- **Laboratory Sheets: Dr. Patel will be the physician for results notification.**



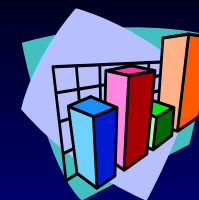
Welcome to Family Planning Fast Track STI Screening Clinic



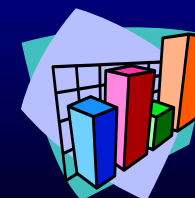
Registration Desk



Welcome & Check-In Station



Data Collection/Analysis



GYT Campaign SYSTEM-WIDE

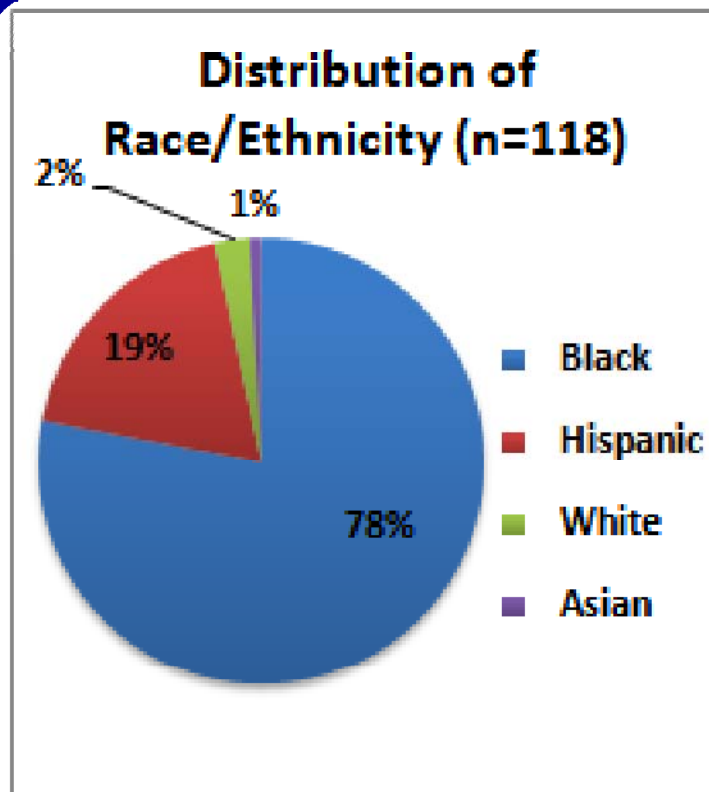


Figure 1

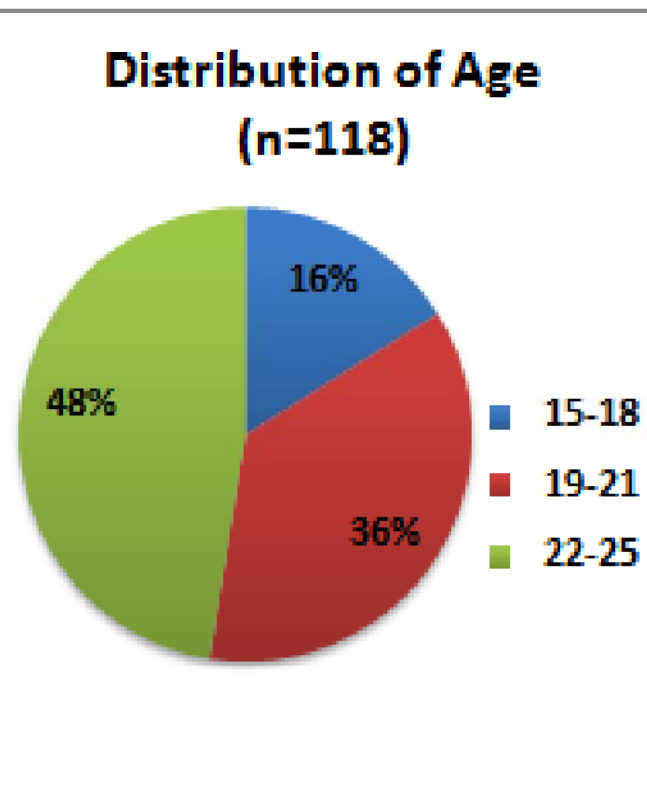


Figure 2

GYT Campaign SYSTEM-WIDE

Jan-April 2011 Quarterly Report

System Wide² Number and Rates (per 100 population) of CT/GC Positive Individuals Jan - April 2011 Quarterly Report

	Male			Female		
	No. Positive	No. Tested	Rate*	No. Positive	No. Tested	Rate*
January	102	355	28.7	138	858	16.1
February	57	258	22.1	133	751	17.7
March	38	192	19.8	89	593	15.0
April	79	371	21.3	141	1030	13.7
Jan-Apr '11	276	1176	23.5	501	3232	15.5
* Incidence rates calculated per 100 population						

Table 1

GYT Campaign SYSTEM-WIDE

Fast Track Screening Clinic (FTS): Demographic and STI Breakdown

Number, Proportion and Rate (per 100 population) of CT/GC Positive Individuals								
n=118	No. Tested	Percent	CT/GC		Chlamydia		Gonorrhea	
			No. Positive	Rate*	No. Positive	Rate*	No. Positive	Rate*
Sex								
Male	30	(26%)	5	4.2	5	16.7	0	0.0
Female	88	(74%)	13	11.0	12	13.6	3	3.4
Race								
Black	92	(78%)	17	14.4	16	17.4	3	3.3
Hispanic	22	(19%)	1	0.8	1	4.5	0	0.0
White	3	(2%)	0	0.0	0	0.0	0	0.0
Asian	1	(1%)	0	0.0	0	0.0	0	0.0
Age								
15-18	19	(16%)	2	1.7	2	10.5	1	5.3
19-21	43	(36%)	9	7.6	8	18.6	2	4.7
22-25	56	(48%)	7	5.9	7	12.5	0	0.0

GYT Campaign SYSTEM-WIDE

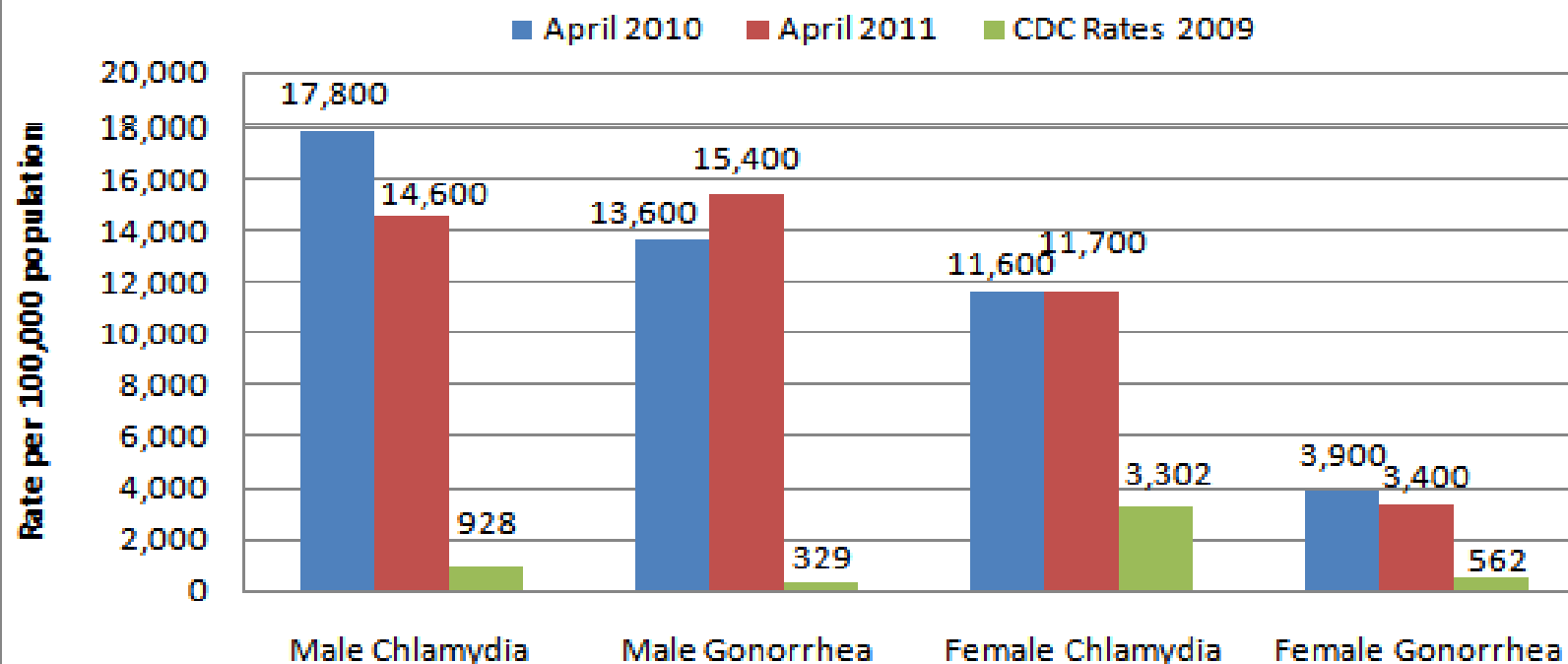
April 2010 vs April 2011: STI CT/GC Positive Individuals

System-Wide ² Number and Rate (per 100 Population) of CT/GC Positive Individuals April 2010 vs April 2011						
	Male			Female		
	No. Positive	No. Tested	Rate*	No. Positive	No. Tested	Rate*
April '10	65	236	27.5	114	813	14.0
April '11	79	371	21.3	141	1030	13.7
* Incidence rates calculated per 100 population						

Table 1

GYT Campaign SYSTEM-WIDE

System Wide Gender Specific CT/GC Rates (per 100,000 population) Ages 15-24 April 2010 vs April 2011



April 2010: n,male = 236 n,female= 813; April 2011: n,male = 371 n,female= 1030

GYT Campaign SYSTEM-WIDE

Fast Track Screening Clinic: Sex and Race/Ethnicity Breakdown

Number and Percent of Individuals Tested by Race and Sex				
	Male (n=30)		Female (n=88)	
	n	%	n	%
Black	20	67%	72	82%
Hispanic	8	27%	14	16%
White	1	3%	2	2%
Asian	1	3%	0	0%

Table 1

GYT Campaign SYSTEM-WIDE

Fast Track Screening Clinic: Healthcare Questions

Healthcare Questions: Testing History and Provider				
	Male		Female	
	n	%	n	%
Testing History*	n=29		n=85	
Yes	6	21%	40	47%
No	13	45%	36	42%
Not sure	10	34%	9	11%
Regular Doctor†	n=28		n=82	
Yes	5	18%	43	52%
No	23	82%	39	48%
* 1 male and 3 females did not answer this question				
† 2 males and 6 females did not answer this question				

Table 1

GYT Campaign SYSTEM-WIDE

Cumulative Distribution of Individuals Tested for STIs

	J. Stroger Hospital and Affiliated Clinics ^b (i.e. Core, Provident, ACHN Clinics)	Fast Track Screening (FTS) Clinic (Fantus)	Morton East High School	Core Center (GYT)	Rapid HIV Testing (Core)	Jail ^b	Juvenile Detention ^b	System Wide Total
STI Tested								
CT	1401	118	94	290	-	100	435	2438
GC	1401	118	94	290	-	100	435	2438
RPR	908	-	8	-	-	138	150	1204
HIV Anti-body (ABHIV)	826	-	8	-	-	116	227	1177
Rapid HIV (HIVRS/ HIVRP)	84	-	-	-	212	-	-	296
Total Screens Performed	4620	236	204	580	212	454	1247	7553

GYT Campaign SYSTEM-WIDE

Gender								
Male	371	30	34	121	112	109	390	1175
Female	1030	88	68	168	99	245	40	1739
Transgender	0		0	1	1	0	0	2
Positivity Data by Gender								
Positive Male GC/CT	79	5	12	-	-	4	54	154
Positive Female GC/CT	141	13	0	-	-	14	6	174
Positive Male RPR	-	-	8	-	-	1	1	10
Positive Female RPR	-	-	0	-	-	5	1	6
Positive Male HIV	-	-	0	-	0	0	0	0
Positive Female HIV	-	-	0	-	0	0	0	0
Positive Transgender HIV	-	-	0	-	1	0	0	1

Contact Information

Kenneth Campbell, MPH, MBA, MA
Program Manager,

2012 Sexually Transmission Infection (STI)
System-Wide Program

Cook County Health & Hospitals System
(CCHHS)

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Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #2

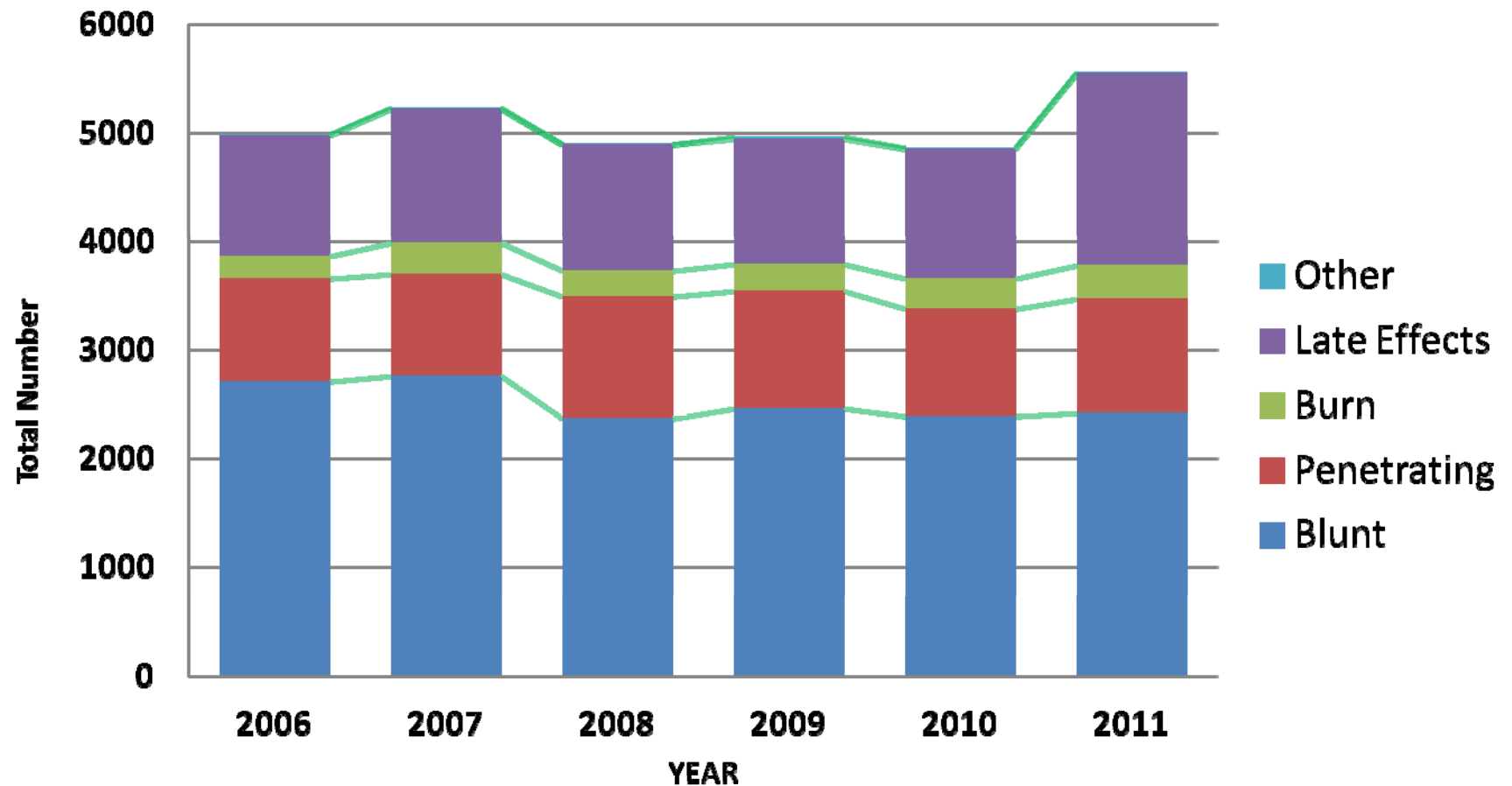


TRAUMA/BURN QA 2011

Dr. Faran Bokhari
Chair,
Dept of Trauma and Burns
CCHHS



Department of Trauma and Burns Encounters By Injury Type



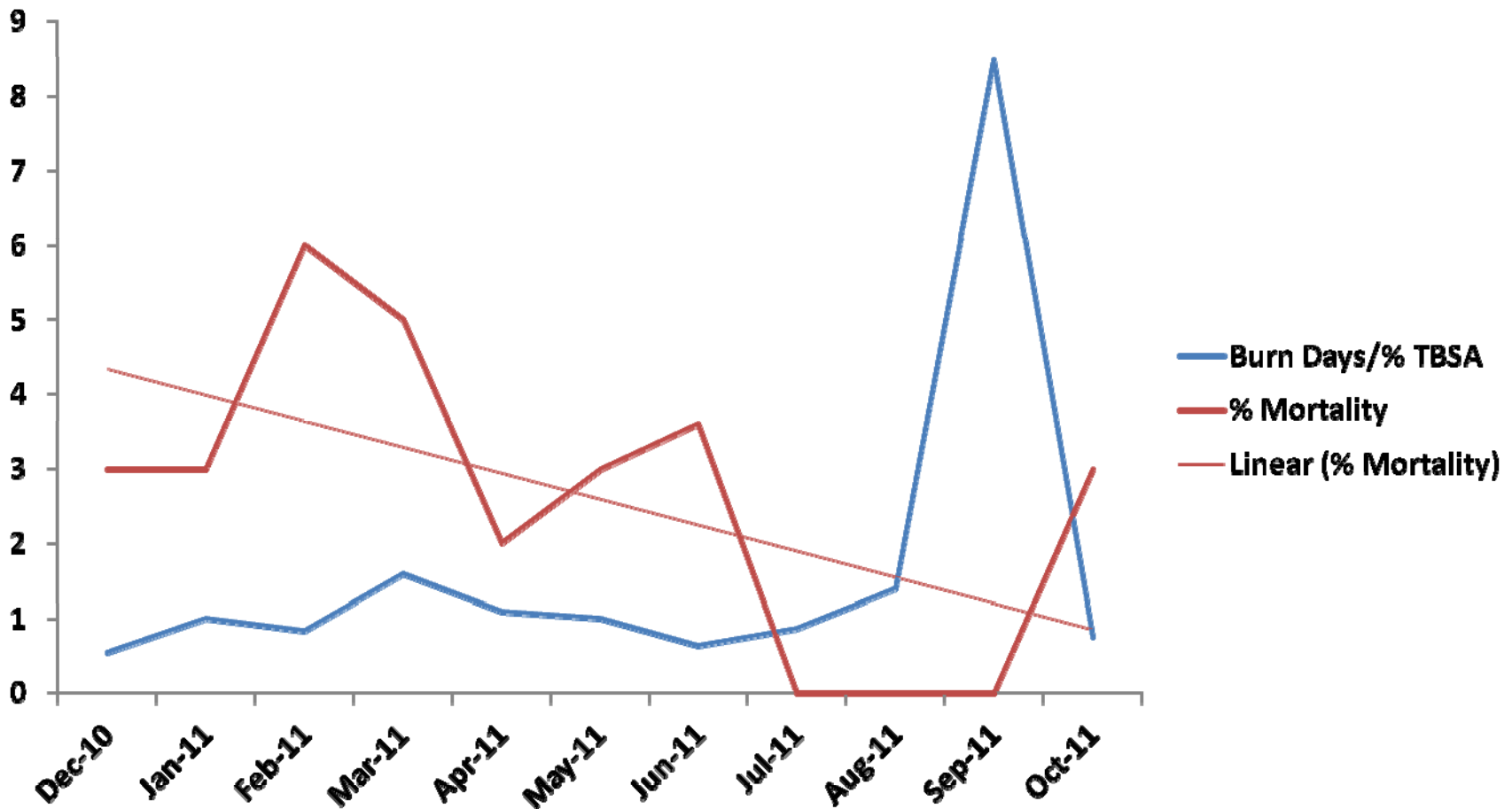
TRAUMA DASHBOARD

2011

Trauma Quality Indicators	Current	Benchmark	Target	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
ICU indicators															
VAP (#/1000 vent days)--4.5	4.5	(6-9.3)	10	0	0	16	0	0	0	11.5	0	10	0	10	6.5
UTI (#/1000 cath days)--12.2	12.2	(3.2-5.7)	10							3	14	16	10.5	15	14
CLABSI (#episodes/1000 line days)--2.6	2.6	(2-4)	5	13	0	0	0	0	0	7	0	8	0	0	0
UGI bleeds (% of census)				0	4	0	0	0	3.3	0	0	0	0	0	0
DVT/PE (% of census)	0.9	10	10	0	0	0	0	0	0	0	2.8	0	0	0	8
Stage III/IV decubitus (%of census)	0.5	0	0	0	0	0	0	0	0	0	2.7	0	0	3.7	0
Self-Extubations	1.4	0	0	0	4	2.8	2.6	0	0	2.1	0	2.6	3	0	0
Re-Intubations (%/census)	0.6	15	15	0	0	0	0	0	0	2.1	2.7	2.6	0	0	0
Operative Indicators															
						2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Preop Antibiotics (% of patients)	99	100	100									93	98	99	99
SCDs (% of patients)	100	100	100									93	99	99	100
Operative Diagnostic Accuracy															
Therapeutic Laps (% of laps)	95.5	80	80			82.0	87.0	81.0	89.0	87.0	84.0	85.0	94.0	93.0	95.5
Non-therapeutic laps (%of laps)	5.5	15	15			15.0	6.0	7.0	8.0	10.0	11.0	NA	3.6	4.5	5.5
Negative Laps (%of laps)	0	5	5			3.0	6.0	12.0	4.0	4.0	4.0	NA	2.3	2.3	0.0

Department of Trauma & Burns

Burn Center Data 2011



Department of Trauma and Burns

- FUTURE DIRECTIONS

- ***OUTREACH/BRAND ALIGNMENT***

- PRE-HOSPITAL EDUCATION-HOSPITALS AND PROVIDERS—June conference
- ACS TRAUMA CENTER VERIFICATION
- ABA CERTIFICATION

- ***DIFFERENTIATION***

- GERIATRIC TRAUMA AND WOUND CENTER

THE DEPARTMENT OF TRAUMA AND BURN SERVICES





Critical Care Mortality Data

- ❑ Deaths in ICUs Retrieved from Cerner
- ❑ Mortality Compared to External Benchmarks
 - SAPS II (MICU, SICU, NEICU)
 - Injury/Burn Severity Scores (Trauma/Burn)
- ❑ Cases reviewed as expected/unexpected
 - Expected Mortality:
 - ❑ patient with continuous deterioration
 - ❑ Patient with expected disease progression,
 - ❑ Patient DNR or withdrawal of care.
 - Unexpected – Does not meet above criteria



Example: MICU Mortality Data 2011

- Mean Mortality was 13%
 - (total deaths/total admissions)
- Mean SAPS II = 33
 - (Predicted Mortality of 16%)
- Mean SAPS II of patients who died was 48
- Total Unexpected Deaths – 18/150 or 12%
- Variability by month will be examined further



Improving Physician, Nurse, Therapist Communications – Daily Rounds Sheets

- ❑ Filled out by night nurses and endorsed to day shift.
- ❑ Day shift reviews with medical team on morning rounds
- ❑ Meets the TJC requirements for Plan of the Day



Improving Physician, Nurse, Therapist Communications – Daily Rounds Sheets

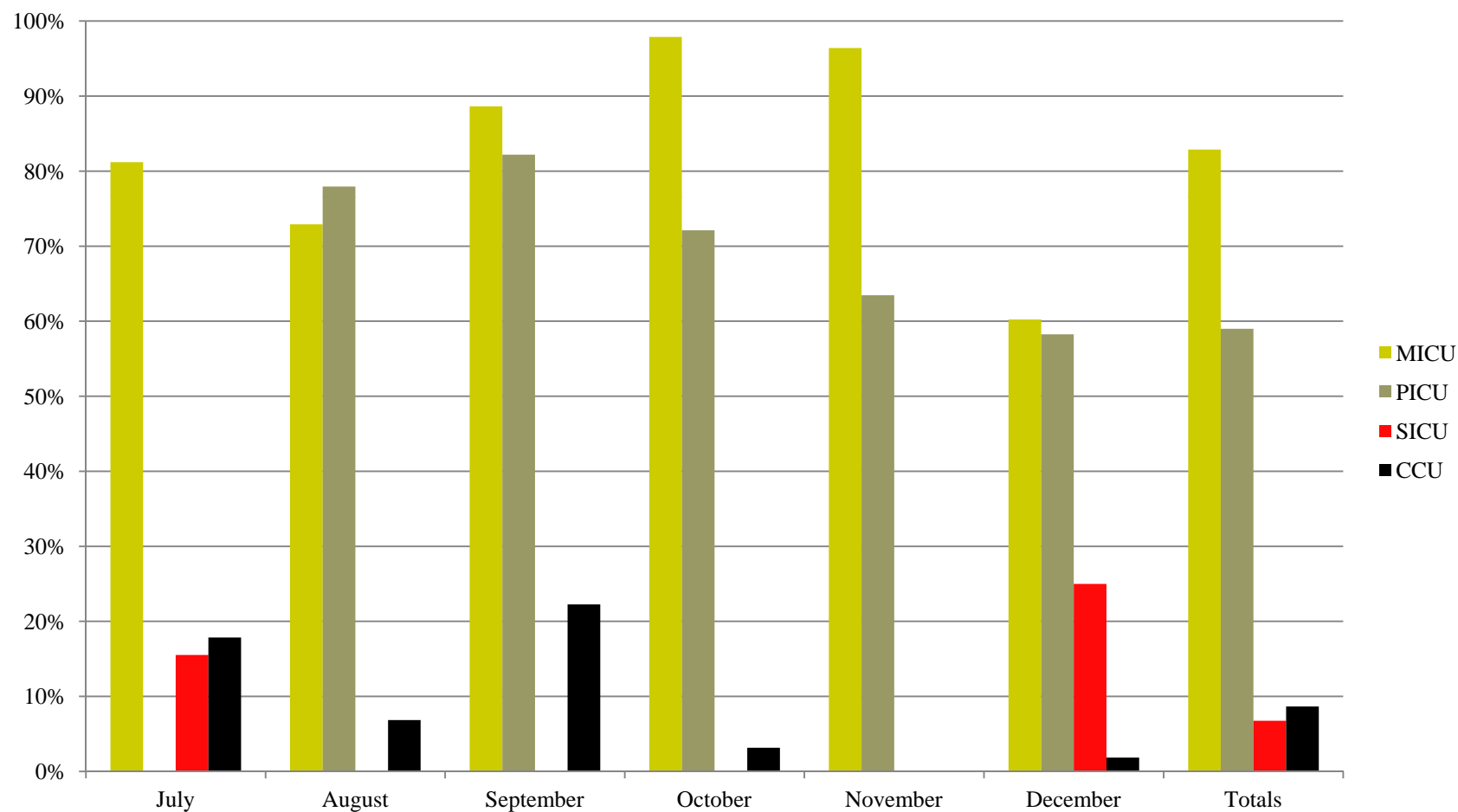
- ❑ Reviews Compliance with Vent Bundle
 - Prevention of Ventilator Associated Pneumonia
- ❑ Nutrition and Fluid Balance
- ❑ Activity
- ❑ Procedures
- ❑ Consults
- ❑ Family Meetings



Daily Rounds Sheets – Compliance

- ❑ Data from Daily Rounds Sheets Entered into Database
- ❑ Number of Sheets Compared to Daily Census
- ❑ Provides Estimate of VAP Bundle compliance
- ❑ MICU, TICU, PICU have good compliance
- ❑ Room for improvement in Burn, Neuro, CCU and NICU

Daily Rounds Sheets - Compliance





Future Plans For Critical Care

- Mortality Data for all Units compared to appropriate indicators for disease severity
 - MICU, Trauma, Burn, NICU – all have current data
 - SICU, CCU, NECU – need to develop these measures
 - Forward review of unexpected deaths to QA and expand to all units
- Updated Sedation and Daily Awakening Trials

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #3

EXECUTIVE SUMMARY

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY **QUALITY ASSESSMENT AND IMPROVEMENT PLAN**

John H. Stroger, Jr. Hospital of Cook County is committed to the continuous assessment and improvement of the quality of patient care provided and to the reduction of morbidity and mortality among patients receiving care by hospital personnel.

The purpose of the Plan is to design a systematic and organization wide approach to achieving the goals related to the improvement of clinical and administrative processes and functions. It identifies the connection between organizational performance and judgements about quality.

The Plan provides for measurement and assessment of individual and multi-disciplinary patient care services from a variety of data sources including peer review, comprehensive and focused studies, indicator monitoring, critical paths, and continuous quality improvement teams for the sole purpose of improving patient health outcomes.

The Plan sets forth a mechanism to collaboratively integrate and coordinate all review activities with an emphasis on the prioritization of known or suspected issues that are high risk, high volume, or otherwise exert major impact on organizational performance.

Furthermore, the Plan promotes communication and reporting of quality care issues to those identified with authority and responsibility to establish and maintain effective hospital wide information, data, reports, minutes, or memoranda relating to all activities addressed in the Plan.

The Cook County Health & Hospitals System Board, as the governing body of John H. Stroger, Jr. Hospital of Cook County delegates this function to the System Quality and Patient Safety Subcommittee of the Board, Executive Medical Staff and Hospital Administration through the Quality Assessment and Improvement Committee.

Amended 2/10/2012

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
QUALITY ASSESSMENT AND IMPROVEMENT PLAN

2012

TABLE OF CONTENTS

- I. Statement of Policy
- II. Authority
 - Cook County Health and Hospitals System Board
 - System Quality & Patient Safety Committee
 - Executive Medical Staff
 - Hospital/Administration
 - Quality Assessment and Improvement Committee
 - Department of Quality Assessment & Improvement
 - Department of Risk Management
 - Department Chairs and Medical Staff
 - Medical Staff Committees and Committee Chairs
- III. Scope
 - Departments
 - Committees
 - Ancillary and Support Services
 - Hospital Oversight
 - Patient Safety Committee
- IV. Design
 - High Risk Processes
 - Performance Improvement Team Initiatives
 - Projects and Goals 2011
 - System-wide Projects
 - Hospital-wide Projects
 - Inpatient and Outpatient Measures
 - Thresholds
 - Data Collection
 - Assessment
- V. Improvement Action
- VI. Evaluation and Documentation of Improvement
- VII. Communication
- VIII. Plan Approval/Amendment
- IX. Confidentiality
 - Appendix I: Membership
 - Appendix II: Inpatient Hospital Quality Measures

**JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE
QUALITY PLAN**

August,	1991	(revised)
January,	1994	(revised)
September,	1994	(revised)
September,	1997	(revised)
September,	2000	(revised)
September,	2003	(revised)
December,	2004	(revised)
December,	2005	(revised)
November,	2009	(revised)
March,	2010	(revised)
May,	2010	(revised)
March,	2011	(revised)
February	2012	(revised)

I. Statement of Policy:

John H. Stroger, Jr. Hospital of Cook County, a public acute care facility, operates all services and departments that provide comprehensive quality health care for inpatient and outpatient specialty care to the citizens of Cook County, especially those with limited financial resources.

John H. Stroger, Jr. Hospital of Cook County is committed to the continuous assessment and improvement of the quality of patient care provided and to the reduction of morbidity and mortality among patients receiving care by hospital and clinic personnel.

The purpose of the Quality Assessment and Improvement Plan for John H. Stroger, Jr. Hospital of Cook County is to support the mission of the hospital and to establish a planned, systematic, organization wide approach to the performance improvement process that includes an effective mechanism to design, measure, assess, and improve performance in the care provided to all patients. The plan is designed to collaboratively integrate and coordinate all review activities relating to Quality Improvement, to include but not be limited to Quality Assessment and Continuous Quality Improvement, Performance Outcome Improvement, and Case Management Review. The plan provides for a comprehensive, objective, and effective assessment of important aspects and functions of patient services based on one standard of care, and focuses on the identification and resolution of known or suspected issues that have an impact on patient care outcomes and on the continual improvement of performance. Furthermore, the Plan promotes communication and reporting of quality care issues among Hospital Administration, Department Chairs, Committees, Ancillary and Support Service Directors, and the Cook County Health & Hospitals System Board.

II. Authority:

Cook County Health and Hospitals System Board:

The Board of Directors of the Health & Hospitals System, as the governing body of John H. Stroger, Jr. Hospital of Cook County, shall maintain ultimate authority and responsibility for the Quality Assessment and Improvement Program, striving to assure quality patient care by requiring and supporting the establishment and maintenance of an effective Hospital Wide Quality Assessment & Improvement Program.

The Board of Directors set priorities for data collection and identifies the frequency of data collection.

The Board, by approval of this Quality Assessment and Improvement Plan, delegates authority and responsibility to perform this function to the System Quality and Patient Safety Subcommittee, Executive Medical Staff (EMS) and Hospital/Administration through the Quality Assessment Committee (QAIC), Department Chairs, Ancillary and Support Service Directors. The Board shall:

- * receive and review periodic reports of findings, actions, and results of actions from the Quality Improvement Program;
- * approve the Quality Assessment and Improvement Plan which includes an assessment of the program's efficiency and effectiveness;
- * Establish goals for the next year;
- * recommend appropriate organizational and/or activity modifications;
- * assure that the primary goal of patient care quality is achieved through review and appropriate deployment of adequate resources.

Documentation from Board actions will reflect conclusions, recommendations, actions, and follow-up relating to the monitoring and evaluation process.

System Quality and Patient Safety Committee:

The System Quality and Patient Safety Committee serves as the system-wide liaison to the Cook County Health & Hospital System Board. Its functions include the communication of recommendations on policies pertaining to the quality of patient care.

Executive Medical Staff:

The Executive Medical Staff (EMS) is the organization of the medical staff of John H. Stroger, Jr. Hospital of Cook County as identified in the Medical Staff Bylaws. The EMS is authorized and directed to review, approve, implement, and communicate the quality assessment and improvement activities of the medical staff and its Committees to the Joint Conference Committee on a monthly schedule. The EMS receives a minimum of annual reports of QA activities from the Medical Staff Departments and Committees. In addition, through the Credentials Committee and peer review, the EMS participates in the reappointment of medical staff and the conduct of periodic and focused performance review of the respective members of the medical staff.

Hospital/Administration:

Hospital/Administration insures that appropriate professional and technical staff members from various departments participate in the Quality Assessment and Improvement Program in order to facilitate multi disciplinary patient care. Findings and recommendations are reported to the respective Medical Staff and/or QAIC as appropriate.

Hospital/Administration provides the administrative support necessary to facilitate the ongoing operation of the Quality Improvement program including analyzing information and acting upon systems/processes involving administrative services and hospital policies.

Quality Assessment and Improvement Committee:

The Quality Assessment and Improvement Committee is an administrative and medical staff committee which includes representatives from the major disciplines of health care (See Appendix I). Leadership of the committee is provided by Hospital Administration and EMS. While not in session, the Committee shall perform its functions through the activities of its members and through the Quality Assurance Department of Medical Administration.

All activities described in this plan are the activities of the QAIC insofar as they are directed to be performed by this Committee and are intended to serve as a vehicle for gathering and disseminating information in order to fulfill the Committee's objectives of improving the quality of patient care at the hospital.

The QAIC shall direct and require Clinical Departments, Hospital Departments, Ancillary and Support Services, Committees to conduct quality assessment and improvement activities. These activities shall be subject to review and approval by the QAIC and shall focus on the identification of areas of possible improvement with respect to the functional delivery of care. These activities shall be reported to the QAIC, which shall facilitate, coordinate and evaluate corrective actions taken and conduct follow-up activities to ensure problem resolution.

The QAIC shall prioritize concerns according to their direct effects on patient care and may refer matters to the appropriate Administrator, Department, Ancillary or Support Service, or committee for action. In addition the QAIC shall:

- * establish hospital-wide QI goals for the year;
- * appoint multi disciplinary teams to conduct problem solving and performance improvement activities at the direction of the QAIC;
- * monitor the degree to which each department, committee, and services comply with the directives of this or any subsidiary QA plan;

Quality Assessment and Improvement Committee Continued:

- * review the reports of regulatory agencies and the corrective action plans promulgated in response to these reports to ensure that they are implemented and evaluated;
- * review and approve recommended corrective actions, including the development of hospital policies and procedures having impact, direct or indirect, upon the quality of patient care provided at the Hospital;

- * request that appropriate persons including, but not limited to, the Director of the Department of Quality Assessment or their designees and the Hospital Oversight Committee to conduct investigations and other monitoring activities on behalf of the QAIC;
- * designate members of the Committee to serve as reviewers for the purpose of reviewing and evaluating quality assessment and improvement activities of assigned departments, services, and committees including plans, indicator studies, and summary reports prepared pursuant to this Plan.
- * review this plan and if necessary submit proposed changes to the Patient Quality and Safety Committee for review and approval.

Department of Quality Assessment & Improvement:

The Department of Quality Assessment shall provide administrative and technical support to the QAIC and shall facilitate the functions of the QAIC between intervals when the Committee is not in session. The Director of the Department of Quality Assessment shall be a member of the QAIC and shall direct the department to perform such functions as shall supplement, coordinate, and facilitate the quality assessment and improvement activities conducted pursuant to this Plan.

The Department shall regularly consult with and review information from data generated throughout the Hospital as required by the implementation of this Plan. This information shall include, but not be limited to, surveys of external agencies, indicator trending reports, patient and staff surveys, incident reports and reports and data of the various departments, services, committees and personnel relative to activities conducted pursuant to this Plan.

The Department shall provide administrative and technical support for quality reviews and other performance improvement teams and insure that results of these teams are reported to the QAIC.

The Department shall provide support for the Hospital Oversight Committee.

Department Chairs and Medical Staff:

The Department Chairs and Medical Staff are responsible to The Executive Medical Staff and the QAIC for main-

taining a consistently high level of quality patient care and the evaluation of clinical performance of all individuals with delineated clinical privileges.

As a part of the Quality Improvement Program, opportunities to improve care will be addressed by participating in this QAIC Plan.

Medical Staff Committees and Committee Chairs:

The Medical Staff Committees and Committee Chairs shall be responsible to the Executive Medical Staff and QAIC for maintaining consistently high level of quality patient care.

In accordance with the structure of the Medical Staff described in the Bylaws, medical staff members will be assigned to committees and will be responsible for measuring, assessing, improving, and reporting the status of patient care at Committee meetings. Included in its functions are the evaluation of the clinical performance of all individuals with delineated clinical privileges and for improving quality care.

III. Scope:

The Quality Assessment and Improvement Program at John H. Stroger, Jr. Hospital of Cook County provides oversight for all quality assessment and improvement activities conducted by the Hospital. The program includes both direct and support services for all patients.

Departments:

Each of the Hospital Clinical Departments including Pharmacy and Case Management shall form a departmental QA&I Committee which shall adopt and implement a Quality Assessment and Improvement Plan which shall be subject to the approval of the QAIC. Each department is directed to monitor, evaluate and improve the quality of patient care within its scope of care or services.

Committees

The Hospital shall organize and support the Hospital Committees to carry out specific quality assessment and improvement functions. Committees shall include, but are not limited to:

1. Case Management

2. Blood Review
3. Critical Care and Resuscitation
4. Drug & Formulary and its Subcommittees:
 - Drug Usage Evaluation
 - Anti-infective
5. Infection Control
6. Medical Records
7. Surgical Function Review
8. Hospital Oversight
9. Environment of Care
10. Bioethics
11. Patient Safety
12. Cancer Committee
13. Perinatal Committee

Ancillary and Support Services

Each of the following Ancillary and Support Services shall conduct activities required by the QAIC for monitoring and evaluating the quality of services they provide as they affect patient care and shall report the results of these activities to the QAIC through the Department of Quality Assessment. These include:

1. Dietary
2. Language, Speech & Hearing/Physical & Occupational Therapy
3. Medical Records
4. Building & Grounds
5. Clinical Engineering
6. Communications/Mail
7. Environmental Services
8. Materiel Management
9. Patient Relations
10. Transportation
11. Interpreter Services
12. Finance/Supply Chain
13. Admissions/Bed Control
14. Information Systems

Hospital Oversight:

The Hospital Oversight Committee undertakes review of sentinel events, never events and other significant patient care issues, including patient care issues involving multiple clinical departments or affecting significant numbers of patients, matters referred to the Committee by the Chairperson of Clinical Departments for resolution, and significant adverse patient care events including events or patterns of adverse events during moderate or deep sedation and anesthesia use and closed or settled malpractice cases. The identification of a sentinel event shall require

the hospital to undertake a root cause analysis in order to identify systems that can be redesigned in order to prevent the reoccurrence of a similar event. The Committee, upon conclusion of its review, shall recommend appropriate corrective actions for the purpose of reducing morbidity and mortality and for improving the quality of patient care. The results of these activities will be reported to the QAIC.

Patient Safety Committee:

The Patient Safety Committee is an administrative and medical staff committee with multi-disciplinary membership. The charge of the committee is to assist the hospital in incorporating the National Patient Safety Goals into policy and practice by assessing patient safety and making recommendations related to the goals. The Patient Safety Committee also works with hospital staff and administration to reduce the occurrence and risk of medical error through:

- monitoring of data related to patient safety to identify opportunities to improve patient safety
- analysis of data, occurrences, and near-misses to determine root causes and understand systems problems that have a negative or positive effect on patient safety. The Committee receives reports relevant to its charge from other departments and committees. The Committee receives referrals from the Hospital-Wide QAI Committee and the Hospital-Wide Oversight Committee and also will forward reports and make referrals to those Committees as appropriate.
- makes recommendations for interventions, reactive and proactive, which address and correct identified risks to patient safety and prevent occurrences.
- evaluation of the effectiveness of implemented recommendations
- education of hospital staff and patients on patient safety

The Patient Safety Committee reports on its activities to the Hospital-Wide QAI Committee, to the EMS, Hospital-Administration and the Quality and Patient Safety Committee of the Systems Board.

IV. DESIGN

The QAIC Plan provides for a planned, systematic, and ongoing process for designing, measuring, assessing, and improving the quality of care and of key governance, managerial, and support activities encompassing functions that are most important to the health and safety of the patients served.

Quality Assessment and Improvement activities shall be patient centered, performance focused and organized around key functions common to health care organizations.

High Risk Processes:

The organization shall collect data that measure each of the following:

1. Occur frequently and/or affect large numbers of patients
2. Place patients at serious risk if not performed well, or performed when not indicated;
3. Tend to produce problems for patients or staff

Performance Improvement Team Initiatives:

The QAIC shall appoint multidisciplinary teams to conduct problem solving and performance improvement activities at the direction of the QAIC.

Requirements:

- a. All Performance Improvement Teams shall follow the Focus, Plan, Do, Check, Act Model.
- b. The composition of the teams shall reflect the multi-disciplinary nature of the process under study.
- c. Departmental teams shall be appointed and supported by the Chairman or Director of the respective unit. Results will be included in their QA reports.
- d. Any team whose scope crosses departments or involves hospital systems and or processes shall be appointed upon approval of the QAIC.

All multi-disciplinary/institutional performance improvement teams shall utilize the following framework for teams:

FOCUS

1. Define, in collaboration with the QAIC, the focus and scope of the performance improvement

PLAN

2. Review existing information:
 - a. literature and other benchmarking information
 - b. sources of internal information/data

- c. establish performance standards
- d. Develop a review instrument specific to the process or population under study
- e. establish performance goals

DO 3. Collect and analyze data

CHECK 4. Evaluate data; plan for periodic monitoring

ACT 5. Develop recommendations specific to project/population/systems
 6. Implement approved changes
 7. Re-monitor/re-assess

The QAIC shall be responsible for evaluating and prioritizing institutional and multi disciplinary PI initiatives. The QAIC shall provide oversight, support and necessary resources.

Projects and Goals for 2012:

System-wide Projects:

- 1. Care of the Diabetic Patient
- 2. Care of the Patient Requiring Anticoagulation

Hospital-wide Projects:

- 1. Acute Myocardial Infarction
- 2. Heart Failure
- 3. Pneumonia
- 4. Surgical Care Improvement Project
- 5. Stroke
- 6. Hospital Consumer Assessment of Healthcare Providers and System Survey
- 7. 30-day risk standardized Mortality Rates (AMI, HF & Pneumonia)
- 8. 30-day risk standardized Readmission Rates (AMI, HF & Pneumonia)
- 9. Agency for Healthcare Research and Quality
 - Abdominal Aortic Aneurysm (AAA) Mortality Rate
 - Hip Fracture Mortality Rate
 - Mortality for Selected Surgical Procedures
 - Mortality for Selected Medical Conditions
- 10. Ventilator Acquired Pneumonia
- 11. Turn-Around-Times (To be defined by June, 2012)
- 12. Throughput

Hospital staff shall participate in system-wide and hospital-wide performance improvement activities designed to standardize and improve the care delivered to the above listed patient populations. Indicators will be developed by the respective teams and regular data collection and analysis shall occur. These teams shall report to the

HWQA&IC on a quarterly basis.

Inpatient and Outpatient Measures:

The Hospital shall continue to participate in the required Core Measures for The Joint Commission (TJC), the Hospital Alliance Measures for Hospital Compare and the Hospital Quality Data for Annual Payment Update (RHQDAPU) Program, along with submission of data for the SCIP and Nursing Staffing measures for the Illinois Report Card Act.

Performance improvement efforts will focus on:

1. PCI within 90 minutes of hospital arrival
2. Surgical Care Improvement Project
3. Smoking Cessation
4. Restraint Use
5. Various Measures of Patient Satisfaction

For TJC we participate in AMI, Heart Failure, Stroke and SCIP. In addition, mortality and readmission measures along with a number of AHRQ measures completed from the administrative database are being phased in during 2009 for publication on Hospital Compare (See Appendix II). HCAHPS measures are also submitted quarterly.

The monthly results of these data will be evaluated by the HWQA&IC and necessary improvements undertaken when necessary.

Potential data sources for identification of inter- and intra departmental quality monitors include, but are not limited to:

- ... Staff Opinions and Needs
- ... Staff Perceptions of Risks to Patients and Suggestions for Improving Patient Care
- ... Staff Reports of Unanticipated Adverse Events
- ... Standards of Care
- ... Medical Record Review
- ... Patient Outcomes
- ... Committee/Department Reports/Minutes
- ... Direct Observation
- ... Policies
- ... TJC Standards
- ... Voluntary and Mandatory Accreditation and Licensing Agencies
- ... Current Literature and Research
- ... Multi-Disciplinary Review
- ... Statistical Data
- ... Patient Satisfaction/Patient Complaints
- ... Vendor Consultation
- ... Departmental Oversight
- ... External Comparative Databases

- ... Autopsy Results
- ... Research as Applicable
- ... Medication Error Reports
- ... Closed or settled malpractice cases
- ... Consultant Reports
- ... Organ Procurement Reports/Conversion Rates
- ... Inpatient & Outpatient Quality Measures (Hospital Compare & QIO)

Thresholds:

Thresholds are triggering mechanisms established for determining when care should be further evaluated. Thresholds are expressed as a percent, ratio, or number.

Data Collection:

The frequency of data collection for each indicator is related to:

1. the frequency of the event;

Data Collection Continued:

2. the significance of the event or activity monitored;
3. the extent to which an important aspect of care indicator has been demonstrated to be problem-free.

The data should be organized so that an evaluation of the quality of care can be readily made.

Data available for use in the Quality Assessment and Improvement Committee includes, but is not limited to, the following:

1. Medical Staff Committee Reports
2. Departmental Indicator Trending Reports
3. Patient and Staff Complaints/Satisfaction Surveys
4. Infection Control Reports
5. Occurrence Reports
6. Census/Financial Data
7. Case Management Reports
8. The Medical Record
9. Reports of External Surveys
10. Safety Surveys
11. Incident Reports
12. Management Reports
13. Community Concerns
14. Performance Improvement Reports
15. Managed Care Reports
16. Core Measures
17. The Effectiveness of Pain Management
18. Medication Error Reports

19. Organ Procurement/Conversion Reports
20. Hospital Compare & QIO data

Assessment:

At specific intervals, data collected concerning important aspects, functions, processes of care should be assessed at the unit level. This includes an analysis of trends and patterns in the data collected. When a threshold for evaluations is crossed or negative trend observed, the evaluation should determine whether there is an opportunity to improve care or address the problem. When review of care provided by a practitioner is undertaken, a review by peer is necessary.

V. Improvement Action:

In reviewing this information, the responsible unit or Committee, shall identify opportunities to improve care and recommend appropriate actions be implemented to improve care/processes. If a needed action exceeds the authority of the unit, recommendations are forwarded to the body that has the authority to act.

Improvement Action Continued:

Such action may include, but are not limited to the following:

1. Education and training
2. Development and implementation of new or revised policy and procedures;
3. Staffing changes;
4. Equipment or facility changes;
5. Allocation of administrative resources and support; or
6. Peer review and other performance evaluation procedures
7. Performance Improvement Teams
8. Process redesign
9. Informatics redesign

If a recommendation or corrective action arising from such Quality Assessment and Improvement activities results in the alteration and/or suspension of credentialed staff members' clinical privilege, such recommendation or action is to be reported to the Medical Director for review.

VI. Evaluation and Documentation of Improvement

After actions have been taken, the QAIC or its representative shall assess the effectiveness of improvement efforts. The reevaluation of data occurs at appropriate intervals as consistent with the severity of the problem. The assessment or reevaluation of actions taken shall insure that the action was effective in improving care or resolving the identified problem and shall be documented and reflected in the minutes of the QAIC.

Evaluation of the effectiveness of QAIC Program shall be provided to the Executive Medical Staff and to the Board

through the Joint Conference Committee. The reappraisal will identify components of the Quality Assessment and Improvement Program that need to be added, deleted, or revised. During this evaluation, emphasis will be placed on the objectives, scope, organization, and overall effectiveness of the program.

VII. Communication:

The results of the Quality Assessment and Improvement process are communicated to relevant individuals, departments, or services, to the Hospital Wide Quality Assessment and Improvement Committee, to the Executive Medical Staff, to the System Quality & Patient Safety Committee, and to the Board of Commissioners, as the trustee of John H. Stroger, Jr. Hospital of Cook County.

Annual QA&I reports summarizing and evaluating all activities will be submitted by Departments and Committees to the Director of the Department of Quality Assessment on behalf of the QAIC.

Clinical Departments, Specialty Clinics, Support Services, Professional Affairs and Medical Staff Committees will give an oral presentation before the QAIC at least once each year unless the QAIC chooses to alter the frequency based on need.

VIII. Plan Approval/Amendment:

This plan has been carefully reviewed and has been approved by the members of the Quality Assessment & Improvement Committee, Hospital and Departmental Administration, Medical Staff and Cook County Health & Hospital Systems Board. This plan shall be reviewed and amended as needed.

IX. Confidentiality:

All information, data, reports, minutes or memoranda relating to the implementation of this Quality Assessment and Improvement Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving patient care. As such, they are strictly confidential under the Illinois Medical Studies and Hospital Licensing Act.

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE
REVIEW OF THE QA PLAN

The Quality Assessment and Improvement Committee Plan shall be reviewed at least annually as evidenced by the signatures and dating by the Cook County Health & Hospital Systems Board, Hospital Director, and President of the Executive Medical Staff.

Director, Quality Assessment

Date

Chairperson, Quality Assessment
and Improvement Committee

Date

System Director, Quality, Safety,
Accreditation and Regulatory

Date

President, EMS

Date

Chief Operating Officer

Date

SJK/am
a:2012plan

**Hospital Wide Quality Assessment & Improvement Committee
Membership
2012**

<u>DEPARTMENT</u>	<u>REPRESENTATIVE</u>
Chair/Medical Director	C. Fegan, M.D.
EMS Chairman	D. Goldberg, M.D.
Case Management	L. Wahlfeldt, RN
Hospital Administration	C. Schneider, COO
Nursing	A. Williams, RN
Quality Assessment & Improvement	S. Klein, MPH
Hospital Information Systems	B. Winters/D. Howard
Medical Records	N. Lafayette-Jones
Medicine	K. Das, M.D.
Adult Emergency Services	H. Straus, M.D.
Obstetrics & Gynecology	E. Linn, M.D.
Surgery	R. Keen, M.D.
Pediatrics	S. Echiverri, M.D.
Pathology	M. Sekosan, M.D.
Specialty Care Clinics	D. Hutcherson
Family Practice	S. Gibson, D.O.

APPENDIX I

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #4

I. OVERVIEW

Provident Hospital of Cook County is a public community teaching hospital located on the south side of the city of Chicago. PHCC provides a continuum of care, including inpatient and outpatient services. The services provided are consistent with its Mission, Vision and Value Statements with the central focus on primary care. Clinical services provided include Internal Medicine, Surgery, Emergency Medicine, Gynecology, Family Medicine, Radiology, and Clinical and Anatomical Pathology. Consulting and rotating services available include the full complement of medical and surgical sub-specialties.

Provident Hospital of Cook County is a member institution of the Cook County Health and Hospitals System. Other affiliates include:

John H. Stroger Hospital of Cook County, a tertiary care hospital located on the Westside of Chicago.

Cermak Health Services, the in-house health center for the Cook County Department of Corrections.

Ambulatory and Community Health Network,

Cook County Department of Public Health

The Core Center, a primary and specialty care facility for infectious diseases.

Provident Hospital of Cook County is committed to:

- Providing high quality of care and services in a caring and respectful environment to its patients, practitioners and employees; and
- Providing a safe, personally and professionally satisfying environment for its employees.

A. Mission Statement

Provident Hospital of Cook County fully acknowledges that the essential element of its mission is to deliver health services with dignity regardless of a patient's ability to pay, partner with communities and providers to enhance public health, and advocate for policies that promote the physical and mental well-being of Cook County's residents. Provident Hospital of Cook County is committed to achieving a health care delivery system that is focused upon continuous performance improvement. As such, the employees of Provident Hospital of Cook County will strive to exceed the standards prescribed by its accrediting and regulatory authorities.

B. Vision Statement

The Quality and Performance Improvement Program of Provident Hospital of Cook County is based upon the principle that all staff who contribute to or participate in the delivery of health care are proactively involved in continuous quality improvement activities.

C. Value Statement

Our Rich Tradition Demands Us To:

Respect each person's worth

Performance Improvement Plan 2012

Excel in the performance of our duty

To care for the fortunate and the not so fortunate

Satisfy our customers to give more than expected

Perfect the deliverance of quality care

Educate the community on preventative programs

Cooperate with other institutions on behalf of our client to improve their lives

Teach the importance of doing the best job possible

II. QUALITY AND PERFORMANCE IMPROVEMENT PLAN

Provident Hospital of Cook County has adopted the following performance improvement model, which shall be used for all Quality and Performance Improvement activities as deemed necessary, and all new process designs:

1)Plan

2)Do

3)Check /Study

4)Act

To help ensure achievement of the hospital quality and performance improvement goals, all hospital personnel, including contracted services, will support a system of performance measurement, assessment and improvement. The guiding principles of Provident Hospital of Cook County's Quality and Performance Improvement Program are centered on the dimensions of performance:

Doing the Right Thing

- The efficacy of the procedure or treatment in relation to the patient's condition. The degree to which the care of the patient has been shown to accomplish the desired or projected outcome(s).
- The appropriateness of a specific test, procedure, or service to meet the patient's need. The degree to which the care provided is relevant to the patient's clinical needs, given the current state of knowledge.

Doing the Right Thing Well

- The availability of a needed test, procedure, treatment, or service to the patient who needs it. The degree to which appropriate care is available to meet the patient's needs.
- The timeliness with which a needed test, procedure, treatment, or service is provided to the patient. The degree to which the care is provided to the patient at the most beneficial or necessary time.
- The effectiveness with which tests, procedures, treatments, and services are provided.
- The degree to which the care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcomes for the patient.
- The continuity of the services provided to the patient with respect to other services, practitioners, and providers, and over time.
- The degree to which the care for the patient is coordinated among practitioners, among organizations, and over time.
- The safety of the patient (and others) to whom the services are provided.
- The degree to which the risk of an intervention and the risk in the care environment are reduced for the patient and others, including the health care provider.
- The efficiency with which the services are provided. The relationship between the

Performance Improvement Plan 2012

outcomes (results of care) and the resources used to deliver patient care.

- The respect and caring with which services are provided.
- The degree to which the patient or a designee is involved in his or her own care decisions and to which those providing services do so with sensitivity and respect for the patient's needs, expectations, and individual differences.
- The respect and caring with which services are provided.
- The degree to which the patient or a designee is involved in his or her own care decisions and to which those providing services do so with sensitivity and respect for the patient's needs, expectations, and individual differences.

The leadership at this hospital is committed to creating and nurturing quality. In pursuit of this goal, Provident Hospital of Cook County will:

- Provide those served, externally and internally, with services which conform to clearly established requirements;
- Design or modify the work processes in order to constantly make improvements and to prevent errors; and
- Support employees and physicians by eliminating barriers to quality and efficiency.

This plan specifies how the organization will achieve its quality goal through a formal quality and performance improvement system. Integral to this approach, the leaders have developed and committed themselves to a system which promotes:

- Everyone's commitment to the processes of performance measurement, assessment and improvement in all areas of the hospital
- The expectation that everyone who has contact with patients or provides services which support patient care is motivated to achieve excellence
- An understanding of important processes and critical activities which must be performed well in order to achieve the organization quality goals
- Meeting the expectations of providers and payers in our managed care environment
- Meeting the regulatory, licensure and accreditation requirements of today, and
- anticipates future changes
- The use of information designed to measure, assess and improve performance.
-

A. Governing Board Authority and Responsibilities

The Governing Board has the final authority and responsibility for the implementation of a flexible, comprehensive and integrated quality and performance improvement program which involves the components of assessing, measurement, and designing quality and performance improvement. In meeting this responsibility, the Governing Board oversees the organization's Quality Performance Improvement efforts. In their support of the Quality and Performance Improvement program, the Governing Board undertakes, at a minimum, the following activities:

- 1) Incorporating the findings from quality and performance improvement activities in strategic planning.
- 2) Committing to the provision of financial support for the program so that Administration and the Medical Staff have the necessary resources for education, services, equipment, information management and personnel required to support quality and performance improvement.
- 3) Receiving regular reports of organization-wide quality and performance improvement activities. Using this information to ensure compliance with the intent of the program and to evaluate the achievement of the organization's quality goals.

B. Executive Leadership Committee

The Executive Leadership Committee of Provident Hospital of Cook County's primary responsibility is to set priorities for the Quality and Performance Improvement goals of the organization. The Executive Leadership Committee shall also:

- 1) Ensure compliance with the quality and performance improvement requirements of the Joint Commission on Accreditation of Healthcare Organizations, the Center for Medicaid and Medicare Services, the Illinois Department of Public Health, and other regulatory/accrediting groups.
- 2) Incorporate the findings from quality and performance improvement activities in strategic planning.
- 3) Set expectations, develop plans, and ensure implementation of procedures to assess measure and improve the quality of the organization's performance.
- 4) Direct resources necessary for Quality and Performance Improvement activities.
- 5) Establish, with approval of the governing board, quality goals for the organization.
- 6) Promote coordination and communication of Quality and Performance Improvement activities throughout the organization.
- 7) At least annually, oversee and evaluate the effectiveness of the Quality and Performance Improvement Program in meeting the organization's quality goals; making revisions where necessary.
- 8) Review and approve all Quality and Performance Improvement requests requiring resources.
- 9) Promote participation in the Quality and Performance Improvement Program by those who use or provide the organization's services.
- 10) Promote education about the concepts and techniques of process improvement for medical staff members and all hospital personnel.
- 11) Provide coordination among relevant departments/groups when necessary.
- 12) Approve all visual displays of Quality and Performance Improvement activities.
- 13) In establishing quality goals, the Executive Management Staff shall consider:
 - (a) the organization's strategic plan;
 - (b) available resources;
 - (c) community healthcare needs;
 - (d) suggestions from medical staff members, employees, patients and other external customers;
 - (e) processes that affect a large percentage of patients, place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated, and/or have been or are likely to be problem prone; and
 - (f) The results of comparison (bench-marking) activities.

Membership

The Executive Leadership Committee's Membership consists of representatives of PHCC leadership:

- Chief Operating Officer
 - Chief Medical Officer
 - President, Medical Staff
 - Chief Nursing Officer
 - Chief Financial Officer
 - Director, Public Affairs
 - Director, Information Systems

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- Director, Quality Services
- System Director Quality, Safety, Accreditation and Regulations

Chief Operating Officer

- 1) Accepts responsibility for implementing: a performance improvement process that encompasses the entire health care system; and the policies of Provident Hospital of Cook County.
- 2) Makes provision for monitoring and evaluating the appropriateness of the healthcare center's use of any outside source that provides services to the healthcare center's patients, and the degree to which the services aid in its care of patients.
- 3) Considers relevant results from monitoring and evaluation activities when developing plans and goals for the organization and evaluating performance.
- 4) Communicates results of monitoring and evaluation activities to the Board of Directors and Joint Conference Committee in accordance with Corporate Policies of the Bureau of Health Services of Cook County.

Chief Medical Officer

- 1) Is responsible for the quality of the professional services provided by individuals with clinical privileges.
- 2) Is accountable to the Board of Directors for professional conduct and competency of its members.
- 3) Establishes professional criteria to be applied to applicants for medical staff and allied health membership and/or delineated clinical privileges that are designed so those patients will receive quality care.
- 4) Considers relevant results from the monitoring and evaluation process when recommending re-appointment to the medical staff and/or the granting/renewal of clinical privileges.
- 5) Identified problems regarding resident performance, behavioral, and/or quality issues while providing hospital patient care management will be referred to the appropriate Residency Program Director for recommendation. A report from the Program Director will be prepared within 30 days from referral from the originating medical staff committee and the Family Practice Patient Care Committee which will have final disposition:

Director of Nursing

- 1) Formulates a plan for the provision of the patient care services throughout the health care system that supports improvement and innovation in patient care service.
- 2) Provides that registered nurses evaluate current nursing practice and patient care delivery, models to improve the quality and efficiency of patient care.
- 3) Develops consistent standards for the provision of nursing care within Provident Hospital of Cook County and sees that they are utilized to monitor and evaluate the quality of nursing care provided throughout the organization.

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- 4) Approves nursing policies and procedures, nursing standards of patient care practice parameters.
- 5) Participates with other nursing leaders and leaders from Cook County Health and Hospitals System, Medical Staff, and clinical areas in planning, promoting, and conducting Health Care System Performance Improvement activities.

Other Members of the Executive Leadership Committee

- 1) Support and encourage department /division directors managers as they implement their performance improvement plans.
- 2) Foster collaborative efforts to identify opportunities to improve processes that affect patient outcomes and satisfaction.
- 3) Use results from performance improvement activities, as appropriate, to evaluate service line/support division performance measures.
- 4) To establish quality priorities for the organization at least annually.
- 5) Charter action teams as appropriate to carry out performance improvement activities, especially teams requiring extensive resource utilization.

Other Management Staff

- 1) Identify performance measures relevant to their service line/support division and the processes and key functions associated within their scope of service. Focus their performance improvement activities on the processes and key functions that most affect patient outcomes and satisfaction.
- 2) Use the PDCA problem-solving model and other statistical tools to formulate/assess action, when action is needed to improve care and/or solve problems.
- 3) Support the interdisciplinary team approach to problem solving. Support the participation of service line/support division staff in interdisciplinary team work.
- 4) Comply with the reporting requirements described in this plan.
- 5) Use results from performance improvement activities, as appropriate, to evaluate competency.
- 6) Identify key customers and their requirements; education needs and strategy; process for nominating, screening, selecting and staffing projects/teams; and performance measures to be used to assess progress.
- 7) Provides resources, including education, rewards and recognition time, and establishes financial guidelines for implementing plans and projects/teams. Assesses and communicates progress to the organization.
- 8) Demonstrates commitment to the performance improvement process.

C. Quality and Performance Improvement Committee

(1) Quality and Performance Improvement Committee

The Quality and Performance Improvement Committee is composed of the following:

- COO
- President of the Medical Staff
- Chief Medical Officer

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- Director of Nursing
- Nine (9) physicians representing each clinical department
- Chief Financial Officer
- Director of Information Systems (Ad Hoc)
- Director of Quality Services
- System Director Quality, Safety, Accreditation and Regulations
- Safety Liaison
- Assistant Directors, Quality Services
- Department Heads

The Quality and Performance Improvement Committee shall provide oversight responsibilities for the hospital's Quality and Performance Improvement Program.

- 1) Meet monthly to review performance measurement data and information from the medical staff and hospital departments.
- 2) Evaluate measurement data to ensure activities are consistent with the organization's mission statement, philosophies, and quality goals.
- 3) Recommend approval of the organization's participation in all comparative database projects.
- 4) Evaluate measurement data to identify opportunities for improvement that may not have been recognized by the individual department.
- 5) Ensure that when an opportunity for improvement of an individual's performance is identified, it is referred to the appropriate medical staff or administrative department.
- 6) Review, prioritize, utilize pre-established criteria, and approve the Quality and Performance Improvement Request for cross-departmental projects.
- 7) Refer cross-departmental improvement opportunities selected for action to the appropriate Quality Improvement Team or existing committees comprised of members from all the disciplines/departments involved in the process to be evaluated/improved.
- 8) Promote participation of non-managerial hospital staff and medical staff members on cross-departmental teams and in other assessment and improvement activities related to their functional area.
- 9) Receive quarterly progress reports on all cross-departmental and intra-departmental improvement projects. Track these projects until objectives have been achieved.
- 10) Participate with the Executive Leadership Committee in setting quality goals for the organization.
- 11) Recommend as appropriate, the extent to which outside resources shall be used to perform Quality and Performance Improvement review, measurement and analysis.
- 12) Participate in the annual evaluation of the objectives, scope, organization and effectiveness of the quality and performance improvement process using information received from the medical staff and hospital departments. Recommend changes in the quality goals, management structure or processes as necessary.
- 13) Receive quarterly reports on all departmental quality assessment/quality control measurements
- 14) Receive quarterly reports from the following medical staff and hospital committees:
 - Infection Control
 - Medical Records

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- Surgical Case/Tissue Review
- Pharmacy and Therapeutics
- Bioethics
- Environment of Care Committee
- Utilization Review
- Cancer
- ORPAR

(2) Medical Staff Department Chairs and Leadership

The Medical Staff Clinical Departments/Sections and Medical Staff Committees will perform the following functions:

- Participate in the identification of performance measures relating to the care or services the department provides.
- Using performance measures monitor and evaluates the quality and appropriateness of patient care/service to Identify potential areas for Improvement.
- Prioritize problems/areas for improvement based on patient care impact.
- Communicate necessary information among departments/sections when problems or opportunities to improve patient care/service involve more than one department/section.
- Develop and implement corrective action, and initiate follow up monitoring to ensure resolution effectiveness.
- Document and report in the meeting minutes findings, conclusions, recommendations, actions taken, and results of actions taken.
- Report relevant findings from the Performance Improvement Program to the Credentials and Medical Executive Committees for consideration at the time of reappraisal/reappointment of the Medical Staff and Allied Health Professionals.
- Monitor and evaluate the Performance Improvement Program annually.
- Patient Care Committees/Sections -These committees/sections will be responsible for carrying out the monitoring activities of the department.
- Monitor and evaluate the quality and appropriateness of patient care provided by clinical service contractors.
- Monitor and evaluate the Department's Performance Improvement activities annually.
- Conduct review of medical records for ongoing quality review.
- Provide discharge planning.
- Monitor appropriateness of hospital admissions, continued stay, and length of stay.

(3) Medical Staff Committees

Standing Committees: Pharmacy and Therapeutics, Utilization Review, Medical Records and Infection Control.

When there are significant variations in patterns of medical staff activities relating to patient care, the findings of these committees will be referred to the respective departments/sections and subsequently reported to the Medical Executive Committee..

(4) Hospital Employees

All employees of Provident Hospital of Cook County will be expected to participate as needed in department and multidisciplinary work groups. All employees are encouraged to “think outside the box” and look for new ways that processes could be improved. Toward that end, all employees will receive training on performance improvement.

D. Quality Services Department

The Quality Services Department shall assist the Quality and Performance Improvement Committee and the Executive Leadership Committee in measuring, assessing and evaluating the Quality and Performance Improvement activities at Provident Hospital of Cook County, the department’s functions shall include, but are not limited to:

- 1) Coordinating, conducting, and/or arranging for collection of Quality and Performance Improvement data and information.
- 2) Developing and distributing a schedule for reporting Quality and Performance Improvement activities.
- 3) Providing educational programs on the technical aspects of Quality and Performance Improvement.
- 4) Serving as liaison with external agencies with regard to Quality and Performance Improvement data and information.
- 5) Serving as a resource for interpreting Quality and Performance Improvement requirements.
- 6) Preparing reports for the Quality and Performance Improvement Committee and Forums, Executive Medical Staff Committee, Executive Management Staff, and the Governing Board on the status of Quality and Performance Improvement activities: Assisting the integration of Quality and Performance Improvement activities among Medical, Nursing, and other Clinical and Support departments. Assisting in the provision of Quality and Performance Improvement information to the Credentials Committee and Clinical Department Chairpersons. Coordinating the annual evaluation process.

D. Quality and Performance Improvement Team(QPIT)

As appropriate, Quality and Performance Improvement Teams will be utilized to assist in the planning, designing, measuring, assessing and improving process. Quality and Performance Improvement Teams are multi-disciplinary functional teams that have been

Performance Improvement Plan 2012

assigned an improvement project. QPIT utilize principles and concepts of basic statistical and performance analysis tools to define, analyze, measure and improve the key processes that achieve the objectives required to render quality of care. The Teams will have a defined beginning and projected end. Requests for QPIT can be initiated by anyone in the hospital, and must be approved by the Quality and Performance Improvement Committee and/or the Executive Management Team.

A Quality and Performance Improvement Team will be assigned when it has been determined:

- 1) There is a need to design or re-design a process.
- 2) Situation does not require immediate action or a quick solution.
- 3) A consensus between persons and/or departments is necessary to make the solution work.
- 4) The process crosses departmental boundaries.
- 5) Teams will report quarterly to the appropriate quality forum
- 6) The process is complex.

Problems that arise within day-to-day operations of the hospital are to be resolved by the Department Head. A problem is appropriate for individual manager's decision when:

- a quick decision is required;
- problem is an intradepartmental issue; or
- The problem is a behavior issue.

Team Membership:

Team Membership consists of the following:

- Sponsor
- Leader
- Facilitator
- Members

Sponsor: An impartial member of the Executive Management Staff who has the responsibility of being a liaison and advocate to the Team.

Responsibilities:

- 1) Attend assigned quality and performance improvement project team meetings.
- 2) Work with the team leader to report mission statement, projected goals and progress of the team to the Executive Management Staff on a bimonthly basis.
- 3) Present team results and implementation recommendations to the Executive Management Staff
- 4) Ensures that the Quality and Performance Improvement Team is meeting on a regular basis.

Leader:

An employee who has the responsibility for managing performance improvement activities for a major segment of the process.

Responsibilities:

- 1) Consults with the workgroup facilitator to determine:
 - The selection of workgroup members
 - The design and implementation of quality and performance improvement process
 - Training requirements and education activities necessary for the team
 - Measurements
 - Methods of recording and communicating results
 - Communication methodologies
- 2) Select as team member, employees who have expertise, experience and direct involvement in the process being improved.
- 3) Formulate a clear, concise mission statement and projected measurable and achievable goals for the project.
- 4) Coordinate and integrate activities of team members (to include, logistical coordination and recording of team member meetings, data collection and follow-up).
- 5) Submit completed bimonthly Quality and Performance Improvement Workgroup Progress Report to the Quality and Performance Improvement Team's Sponsor and quarterly to the Quality and Performance Improvement Committee.

Facilitator:

An employee who has training and knowledge of the continuous quality and Performance improvement processes, statistical analysis and team building. Facilitators are impartial team members who are not involved in the Operational/technical aspects of the process.

Responsibilities:

- 1) Act as a quality and performance improvement process consultant to the team leader in the areas of:
 - Selection of appropriate team members
 - Quality tools to be utilized
 - Training
 - Data collection, analysis and measurement tools
 - Methods of recording and communicating results
 - Problem-solving methods
 - Content and sequence of the quality and performance improvement process elements
 - Teamwork and interaction
- 2) Act as a process consultant to team members during the implementation of the quality and performance improvement process.
- 3) Monitor group interaction and quality and performance improvement activities of the team.
- 4) Work with the leader to foster good communication and team building.

Quality and Performance and Improvement Team Member:

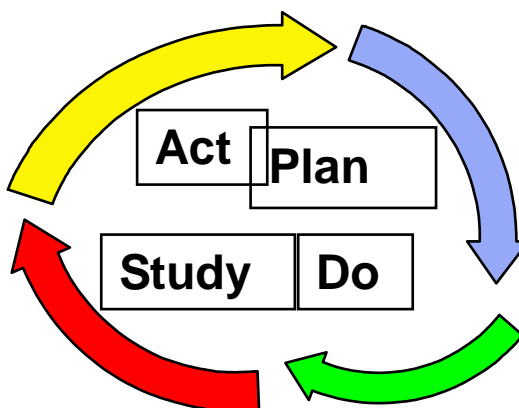
An employee designated by the team leader who has experience and expertise in the process being improved and who is directly involved in the day-to-day

Responsibilities:

- 1) Work as part of the team to utilize quality and performance improvement process techniques to analyze, understand, document and simplify the designated business process.
- 2) Attend meetings and remain until adjournment.
- 3) Agree to participate in discussions.
- 4) Complete assignments in a timely manner.

E. Quality Model

Provident Hospital utilizes the PDCA problem solving methodology to solve problems.



The PDCA cycle is documented on the hospitals Quality ROAD MAP. The ROAD MAP stresses utilization of the seven basic performance improvement tools:

- Process Mapping
- Brainstorming
- Pareto Analysis
- Cause and Effect Analysis
- Failure Mode Effect Analysis
- Flow Charting

Quality Training in the appropriate utilization of the Quality Model is mandatory for all PHCC staff. Training will be provided in various formats on an ongoing basis to provide staff with the tools to participate in a mature quality culture.

All departments must have a minimum of two outcome based measurements which have been selected utilizing the criteria of high risk, high volume or problem prone. However, departments may have more than two measurements as a result of citations incurred as a result of an external regulatory visit.

PLAN

- 1) Plan to improve operations by identifying the problems and changes for resolutions

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Through quality improvement tools, i.e., Flowcharts, Cause and Effect Diagrams, Brainstorming.

- 2) When an opportunity exists to establish a new service, extend a product line, occupy a new facility or redesign function systems, address the following issues.
 - Compatibility with the hospital's mission, vision, values, and other plans
 - The extent to which the needs and expectations of key constituents are met;
 - The extent to which clinically sound and up-to-date (guidelines or parameters) are used;
 - The extent to which sound business practices are utilized; and
 - Establishment of baseline performance expectations to guide measurement and assessment activities.

DO

- 1) Do changes designed to improve/resolve the problems on a pilot basis. This will Allow for an opportunity to re-design interventions intended for resolution of the Problem.
- 2) Develop training programs/on-job training

Check/Study

- 1) Check to determine if interventions are effective through data collection and analysis and utilize the information in the following manner:
 1. Making an informed judgment about process stability,
 2. Pinpointing opportunities for incremental improvements,
 3. Targeting processes in need of redesign, and
 4. Deciding if redesign process have met objectives.

Provident Hospital of Cook County will collect data on:

- patient safety activities
- medication administration errors
- adverse drug reactions
- adverse reactions during anesthesia
- all transfusion reactions
- all major discrepancies between preoperative and postoperative diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures
- autopsy rates/results
- The completeness, accuracy, and timely completion of information in medical records.
- the needs and expectations of patients and others
- staff's views regarding current performance
- nosocomial infections and infection control
- Centers for Medicare and Medicaid Core Measures
- medical staff and employee participation in continuing education
- the effectiveness and appropriateness of orientation, training, and education

Performance Improvement Plan 2012

- provided for by the organization
- quality and performance activities in: clinical laboratory services, diagnostic radiology services, dietary services, nuclear medicine services and pharmacy
- risk management activities
- utilization management activities
- deficiencies, problems, failures, and user errors in safety management, equipment management, and utilities management
- operative procedures
- use of blood/blood components
- use of medication
- licensing, regulatory findings
- Clinical Pathways
- Focused Studies/Clinical Parameters
- Quality and Performance Improvement activities (clinical and non-clinical departments)
- Quality and Performance Improvement Teams

Hospital-Wide Indicators Include:

1. Heart Failure
2. Pneumonia
3. Surgical Care Improvement Project
4. Hospital Consumer Assessment of Healthcare Providers and System Survey
5. 30-day risk standardized Mortality Rates (AMI, HF & Pneumonia)
6. 30-day risk standardized Readmission Rates (AMI, HF & Pneumonia)

Provident Hospital of Cook County will utilize a variety of sources to collect data. These sources include, but are not limited to:

- Department logs
- Benchmarking
- Internal reports
- External data base reports
- Medical Records
- Direct observation
- Customer/Patient Perception Surveys
- Patient Safety Reports
- Root Cause Analysis

ACT

The organization will Act to obtain the optimal benefit from implemented changes by conducting the assessment process in a systematic and collaborative manner via the following tools:

1. Process mapping
2. Process standardization
3. Comparing performance data with pre-established performance expectations
4. Control limits

Conclusions about the need for more intensive measurement will be drawn from the following:

1. Near Misses/Sentinel

Performance Improvement Plan

2. Sentinel Event Alerts
3. Review of all patient safety reports
4. Internal comparison over time
5. External Benchmarking

When the assessment focus is on an individual, the medical staff peer review process is used for licensed independent practitioners. For all other clinical staff, the department director is responsible for using the assessment findings in evaluating staff competence.

If preliminary analysis of performance improvement data reveals that more in-depth analysis is necessary, the team will initiate a root cause analysis (RCA). Root cause analysis will occur when:

- an important single event has occurred (as defined by the hospital)
- performance has not met expected levels of performance
- patterns or trends of performance rates vary significantly and are undesirable from the expected, based on appropriate statistical analysis
- performance varies significantly and undesirably from that of other organizations
- performance varies significantly and undesirably from recognized standards

Redesigning current processes, making incremental improvements, or designing new processes can improve performance and outcomes. Criteria for setting performance improvement priorities shall include:

1. Impact on inpatient functions
2. Impact on the dimensions of performance
3. High Risk, High Volume or Problem Prone
4. Impact on the Strategic Plan
5. Impact on Quality
6. External Regulatory Requirements
7. Impact on Patient Safety
8. Patient/Family Perception/Needs
9. Quality Control
10. Work Redesign
11. Employment Development
12. Recent Breakthrough Innovation/Development

III. ACTION TO BE IMPLEMENTED TO IMPROVE CARE AND SERVICES

Appropriate action to resolve problems and/or opportunities to improve care issues identified from the quality and performance improvement process will be taken.

The action to be taken if the problem/issue involves deficiencies in the system or process includes, but not limited to:

- Changing communication channels
- Using consultant services
- Changing organizational structure

Performance Improvement Plan

- Changing inventory
- Adjusting staffing or redistributing staff
- Revising job descriptions
- Reallocating resources
- Adding or revising policies and procedures
- Altering the use of equipment
- Modifying procedures or processes

The action to be taken if the problem involves deficiencies in staff knowledge includes, but is not limited to:

- Modifying orientation procedures
- Providing focused in-services education
- Providing focused continuing education
- Circulating written policies and procedures or other

The action to be taken if the problem involves behavior or performance deficiencies includes, but is not limited to:

- Revising job descriptions
- Counseling
- Changing assignments
- Disciplinary sanctions
- Placing and individual on probation
- Transferring to another unit/department
- Modifying clinical privileges

IV. CONFIDENTIALITY:

The Quality Services Department and the Medical Affairs Office shall maintain copies of all reports, worksheets, minutes and other data in a manner ensuring confidentiality. This information shall not be released in written form unless requested by:

- 1) Directors of the Systems Board
- 2) Chief Operating Officer or Designee
- 3) Chief Medical Officer
- 4) Director of Nursing
- 5) President of Medical Staff
- 6) Chairperson of Department or Committee responsible for generating minutes
- 7) Legal Counsel
- 8) Director of Quality Services/Designee
- 9) System Director of Quality, Safety, Accreditation and Regulations
- 9) Safety Liaison
- 10) Assistant Directors of Quality Services

All others will have to seek permission from the Chief Operating Officer or the Chief Medical Officer. A coding system shall be used when cases are documented in the minutes.

Performance Improvement Plan

All records, documents, or proceedings of the Quality and Performance Improvement Committee or any quality and performance improvement review functions at Provident Hospital of Cook County shall be:

- Held in confidence
- Not subject to discovery or introduction in any civil action against a physician or other health care professional arising out of matters which are the subject of evaluation and review by such committee or department; and
- Treated for all legal purposes as privileged information.

V. COMMUNICATION OF RESULTS

The findings from the assessment activities of the Quality and Performance Improvement Program will be communicated to other departments, committees and/or individuals as appropriate, and to the Quality and Performance Improvement and Medical Staff Committees, and the Systems Board of Directors.

VI. EVALUATION OF THE EFFECTIVENESS OF QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES

The Executive Leadership and the Quality and Performance Improvement Committees shall participate in the analysis of the effectiveness of all organizational quality and performance improvement activities at least annually. All departments/disciplines will participate in this evaluation, which shall include:

- An evaluation of the organization's progress toward achieving their quality goals.
- An appraisal of the continued relevance of the organization's quality goals and related departmental quality objectives.
- An assessment of the efficiency and effectiveness of the quality and performance improvement program structure, including communication and leadership.

As a result of the evaluation, changes may be made in the quality goals, objectives, and program structure.

At the discretion of the Executive Leadership and the Quality and Performance Committees and the Systems Boards of Directors, changes may be made in the organization-wide quality goals and/or program structure at a time other than during the annual evaluation.

VII: REVIEW/REVISION DATES

Revised May 1996
Reviewed April 1997
Reviewed April 1998
Revised March 1999
Reviewed June 2001
Revised July 2002
Revised September 2003
Reviewed July 2005
Reviewed 2007
Reviewed May 2008
Revised August 2010
Revised April 2011
Revised February 2012

**PROVIDENT HOSPITAL OF COOK COUNTY
QUALITY AND PERFORMANCE IMPROVEMENT PLAN**

APPROVALS:

Representative of the CCHHS System Board of Directors Date

David A. Ansell, M.D., MPH

Interim Chief Operating Officer Date

Tom Dohm

System Director Quality, Safety, Accreditation and Regulations Date

Barbara Farrell, RN, MS MJ

Chief Medical Officer Date

Aaron Hamb, M.D.

Chair, Medical Executive Committee Date

Pierre Wakim, M.D.

Chair, Quality and Performance Improvement Committee Date

Pierre Wakim, M.D.

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #5

**Cook County Health and Hospitals System
Ambulatory and Community Health Network
Quality Improvement Plan
2012**

I. FOUNDATION OF THE CCHHS AMBULATORY QUALITY PLAN

The Cook County Health & Hospitals System (CCHHS) Ambulatory Quality Plan and related quality improvement activities are created and developed based on the mission and vision of the CCHHS.

The CCHHS AMBULATORY & COMMUNITY HEALTH NETWORK MISSION

To deliver integrated health services with dignity and respect regardless of the patient's ability to pay; foster partnerships with other health care providers and communities to enhance the health of the public; and advocate for policies which promote and protect physical, mental, and social well being of the people of Cook County.

VISION

In support of its public health mission, CCHHS will be recognized, locally, regionally, and nationally – and by patients and employees – as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally responsible health care system focused on assuring high-quality care and improving the health of the residents of Cook County.

II. PURPOSE OF THE QUALITY PLAN

- To demonstrate evidence of the commitment of the CCHHS Ambulatory & Community Health Network (ACHN) to the delivery of quality care.
- To outline the framework and structure for identification, implementation, and evaluation of improvements for all clinical and support services in the ambulatory network.
- To establish the reporting and review frameworks that will be used by the Medical Staff, Nursing, and Ancillary Services to systemically report and review the quality and appropriateness of care provided at all of the Ambulatory sites.

In order to assure that the CCHHS Ambulatory and Community Health Network is dynamically responding to the ongoing needs of its patients, staff, and health care delivery system, with the approval of the CCHHS leadership, the plan, frameworks, and structure of its quality program may need to be modified during the calendar year.

III. GOALS AND OBJECTIVES OF THE CCHHS AMBULATORY COMMUNITY NETWORK QUALITY PLAN

The overall goal is to facilitate the mission of the CCHHS and to implement the CCHHS Board's goals and objectives in order to

- promote organizational and clinical excellence,
- maximize patient safety
- provide access to care, and environmental safety
- achieve high levels of patient and staff satisfaction

The CCHHS Ambulatory Quality Plan is designed to:

- A. Coordinate improvement efforts and projects to ensure that capital, staff, facilities and technologies are aligned with strategic priorities for performance improvement.
- B. Implement a quality program with performance priorities
- C. Enable processes and systems that identify and resolve issues and events that may adversely impact patient care and services throughout the Ambulatory Network.
- D. Identify and implement best practices for the provision of safe, cost effective care and services. Benchmark ambulatory services against similar health care delivery systems.
- E. Meet the expectations of our patients, staff, and other stakeholders to improve and maintain patient and staff satisfaction.
- F. Continually assess and monitor ambulatory performance.
- G. Meet accreditation and certification requirements.
- H. Support compliance with all regulatory and licensure requirements.
- I. Track, trend, and communicate patient care and clinical outcomes.
- J. Establish a schedule for reporting of quality measurements, patient care statistics, and improvement projects.

- K. Create an atmosphere of blameless and non-punitive, sustainable quality improvement.
- L. Foster the use of interdisciplinary problem solving throughout the Ambulatory Community Health Network.

The Quality Plan framework utilizes those qualities and values from the work of the Institute of Medicine (IOM, 2001):

- **Safe** – avoiding injuries to patients from the care that is intended to help them;
- **Effective** – providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit;
- **Patient Centered** – providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- **Timely** – reducing waits and potential harmful delays;
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

IV. SCOPE

To achieve the goal of delivering high quality care, all CCHHS employees are given the responsibility and authority to participate in the quality improvement program. The Quality Program includes the following activities:

Data related to the following are collected, analyzed and reported to the appropriate committees/departments/individuals:

- Adverse Events
- Adverse Events related to moderate or deep sedation or anesthesia
- Significant medication errors

- Significant adverse drug reactions
- Patient perception of the safety and quality of care
- Patient Satisfaction
- Employee Engagement
- Infection control surveillance and reporting
- National Patient Safety Goals
- Quality Control related to Lab
- Performance measures related to the Environment of Care Management Plans
- Other measures as determined by Ambulatory staff and leadership the System

Data related to the required measures and patient safety is measured in a number of ways including: monitoring of indicators or processes, patient and staff surveys, reported events, root cause analysis, and other analyses.

V. PERFORMANCE IMPROVEMENT SELECTION

Selection of opportunities for improvement may include one or more of the following mechanisms:

- incorporate goals or important functions of the CCHHS ambulatory network
- evaluation of findings from root cause or failure mode effect analysis
- data, from internal or external sources, which indicate performance problems in a given process and affects a substantial proportion of patients or employees or represents a substantial risk
- risk management
- external data or feedback from various customer or supplier groups related to the process
- data indicating performance or resource utilization problems from department quality improvement activities

Criteria for prioritization include:

- significant potential to improve patient safety
- significant potential to improve the quality of care

- significant potential to increase patient and staff satisfaction
- significant potential to impact efficiency
- significant potential to impact expense or revenue
- processes that cross multiple departments
- advances capabilities to do future improvement projects (such as pilot programs)
- significant potential to achieve strategic goals of system or affiliate

Should there be competition for resources, elective projects will be determined using a weighted matrix of risk and benefit.

VI Comparative Databases and Benchmarks

The Ambulatory and Community Health Network utilizes comparative databases to incorporate a process for continuous assessment with similar organizations, standards, and best practices. This assessment can then lead to actions for improvement, as necessary. Databases that are utilized on an ongoing, routine basis include:

- Illinois Health Connect
- Press Ganey, Inc.
- Illinois Comprehensive Automated Immunization Registry (ICARE)
- Centers for Medicare & Medicaid
- Agency for Healthcare Research and Quality (AHRQ)
- Medical Event Reporting System(MERS)
- SQL server
- Cerner Power Insight

VII. METHODOLOGY

The methodology utilized for improvement is based on the type of project, goals, timeline and scope. The general method for quality improvement in the CCHHS Ambulatory Network is the Define, Measure, Assess, Improve, Control, (DMAIC) approach for improvement activities. The simplest improvement approach will be applied to a problem or issue. The rapid cycle Plan, Do, Study Act (PDSA) improvement processes are encouraged when feasible and appropriate. The Quality Plan recognizes that more complex projects with a wide range of services and staff will require a more structured approach.

VIII. ORGANIZATION AND STRUCTURE OF THE QUALITY PROGRAM

CCHHS Quality Committee Structure

1. Board of Directors receives and reviews regular summary reports from its Quality & Patient Safety Committee concerning quality and patient safety activities and projects, accreditation and regulatory audit visits, and key performance and outcome dashboards. The Board may also receive comprehensive system and affiliate reports and presentations as needed to enhance the Board's understanding and knowledge of especially important, demonstrative, or educational quality projects and outcomes.

2. Quality & Patient Safety Committee (QPSC) of the Board of Directors is the committee of the CCHHS Board of Directors delegated with the responsibility of assuring the effectiveness of the CCHHS' quality program and and reviewing and approving all medical staff credentials and privilege applications in accordance with medical staff bylaws. The QPSC is comprised of three Directors of Board of Directors and other members with experience and expertise in the quality improvement and patient safety in health care delivery systems and organizations. The QPSC provides high level oversight of the effectiveness of quality and patient safety activities of the CCHHS. It approves the Annual Quality Plan, receives summary reports from the System Quality Council, trend reports, dashboards, and corrective action plans on core measures, national patient safety goals, sentinel, never, near miss events, mortalities, and patient and staff satisfaction surveys. The QPSC will also receive occasional comprehensive presentations concerning key system and affiliate quality improvement projects and outcomes.

3. CCHHS Ambulatory Quality Council is responsible for the coordination and oversight of all of the quality improvement activities for the Ambulatory and Community Health Network.. The membership includes quality

improvement staff representation, nursing directors, medical records, medical staff cluster leadership from all of the ambulatory sites.

The Quality Council oversees the quality/performance improvement function across all of the Ambulatory Network, as well as all key processes associated with successful implementation and outcomes. Specifically, the Council shall:

- Develop, modify, and approve the Quality Management and Improvement Plan prior to approval by the governing body;
- Approve Ambulatory Strategic Quality Initiatives, based on the goals of the Strategic Plan, unless approved as part of strategic planning;
- Prioritize the timing of Quality Initiatives and other quality/performance improvement projects based on actual or potential impact on patient care and service and, as available, review of data, as well as system-wide objectives;
- Select the cross-functional, interdisciplinary, and any self-directed QI teams;
- Charter teams for Quality Initiatives or designated QI projects;
- Oversee and support the cross-functional, interdisciplinary teams; facilitate the involvement of settings/departments/services in support of team activities;
- Review aggregated data/information feedback from customer satisfaction surveys; teams; risk safety, infection control, as applicable; and other data/information impacting organization performance;
- Review periodic data/outcome summaries from settings/departments/services for relevance to Quality Initiatives and other team activities.

IX. Confidentiality

All information, reports, statements, or other data that serve or are the outcome of the quality improvement process shall be considered privileged and strictly confidential in their entirety. Such materials shall be used only for the evaluation and improvement of operational processes and patient care. Such materials are not available for review by any individual outside of the quality improvement structure. The above fall within the privilege status under the Medical Studies Act of Illinois, which specifies that such information, is free from discovery and shall not be admissible as evidence.

Ambulatory Council Approval: _____ Date: _____

BF/3-31/2011/ Updated IM 2/28/2012

Ambulatory and Community Health Network

2012 Annual Quality Improvement Measures Appendix

Key Indicators 2012	Numerator	Denominator	Benchmark/Evidence Based practices	Reporting Timeline	Data Collection Frequency
Aim/Goal of Indicator For each indicator describe the aim (Example: Increase pediatric immunization rates at designated clinic sites from 40% to 70% by Dec. 2012)					
1. Assess HgbA1C in $\geq 80\%$ DM patients serviced in ACHN annually.	Total # distinct DM patients w/ HgbA1C within 12 months	Total # distinct DM patients with DM diagnosis in ACHN	Nat'l CMS Benchmark ADA IHC	March/June/Sept/Dec	Quarterly
2. Achieve $\geq 80\%$ update Pediatric immunizations compliance in children 18-24months	Total # Pediatric patient 18-24m with up to date immunization series	Total # patients 18 -24 months old	HEDIS IHC	March/June/Sept/Dec	Monthly
3. Improve annual Patient Influenza immunization rates by 5%	Total number of distinct patients receiving influenza vaccination from 9/1/2011 thru 3/31/2012	Total number of distinct patients with visits in ACHN clinics/facilities from 9/1/2011 thru 3/31/2012	CDC Historical Internal performance data	December	Monthly
4. Assess LDL in $\geq 80\%$ DM patients serviced in ACHN annually	Total # Pt. w/LDL	Total # Diabetic patients in ACHN	Nat'l CMS Benchmark ADA	March/June/Sept/Dec	Quarterly
5. Achieve $\geq 80\%$ Cervical Cancer screening compliance in women	Total # women 21-29y with pap	Total number women 21-29y	USPTF ACOG	June/ Dec	Semi annual

21-29y w/benign pap history Biennially	smear result with 24months.				
6. Achieve \geq 80% Cervical Cancer screening compliance in women 30-65y w/documented benign pap history Triennially	Total # women 30-65y with pap smear result within 36months.	Total number women 30-65y	USPTF ACOG	June/ Dec. 2012	Semi annual
7. Achieve \geq 80% Influenza Vaccination compliance in Prenatal patients	Total # distinct prenatal patients w/ influenza vaccine 9/1/2011 thru 3/31/2012	Total # distinct prenatal patient w/ visits 9/1/2011 thru 3/31/2012	CDC	December 2011 /March 2012	Semiannual
8. Achieve 100% Compliance w/ each Nationally Patient safety Goal	Total # compliant NPSG per category	Total # of NPSG assessments/observations per category	Joint Commission	June/December	Quarterly
9. Achieve \geq 80% overall Patient Satisfaction rate for patients serviced by ACHN	Total # patient respondents rating overall service in ACHN good or very good	Total # distinct patient respondents to Random Press Ganey survey serviced by ACHN	Press Ganey	June/December	Quarterly
10. Achieve telephone answering global score of \geq 80%	Total # telephone calls answered and completed within 90 secs	Total # telephone calls received per ACHN clinics/facilities	Internal Historical performance Data	June/December	Quarterly
11. Achieve 100% compliance w/nurse SOAP format documentation	Total # nurse visits w/ SOAP format documentation	Total # nurse visits	Internal Historical performance data	June /December	Quarterly

Instructions: Please identify those priority quality Improvement activities that your area will be working on for 2012. Your goals should align with the CCHHS Strategic Plan Vision For each indicator describe your aim in detail and describe the numerator, denominator, any benchmarks or targets, the timeline for reporting the data and the data collection frequency.

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
March 20, 2012

ATTACHMENT #6

John H. Stroger, Jr. Hospital of Cook County



Medical Staff Appointments/Reappointments and Non-Medical Staff Action Items, subject to approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Cohen, Stacy, MD Appointment Effective:	Psychiatry/Adult Psychiatry March 20, 2012 thru March 19, 2014	Service Physician
Sadashiva Naik, Gayathri MD Appointment Effective:	Medicine/General Med/ACHN March 20, 2012 thru March 19, 2014	Active Physician
Patel, Jateen, MD Appointment Effective:	Surgery/Pediatrics March 20, 2012 thru March 19, 2014	Voluntary Physician

INITIAL PRIVILEGES FOR NON-MEDICAL STAFF

Goldstein, Deborah, CNP With Lacuesta, Evelyn A., MD Appointment Effective:	Medicine March 20, 2012 thru March 19, 2014	Nurse Practitioner
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REAPPOINTMENT APPLICATIONS

Department of Medicine

Hussein, Lily P.M., MD Reappointment Effective:	Medical Oncology April 17, 2012 thru April 16, 2014	Active Physician
Kavinsky, Clifford J., MD Reappointment Effective:	Adult Cardiology April 16, 2012 thru April 15, 2014	Voluntary Physician
Segreti, John, MD Reappointment Effective:	Infectious Disease April 18, 2012 thru April 17, 2014	Voluntary Physician

Department of Pediatrics

David, Richard, MD Reappointment Effective:	Neonatology May 20, 2012 thru May 19, 2014	Active Physician
Kagalwalla, Amir, MD Reappointment Effective:	Gastroenterology April 18, 2012 thru April 17, 2014	Active Physician
Mathew, Lilly, MD Reappointment Effective:	Hematology/Oncology May 20, 2012 thru May 19, 2014	Active Physician
Stahl, Christiane, MD Reappointment Effective:	Adolescent Medicine May 20, 2012 thru May 19, 2014	Voluntary Physician
Serrato-Buevento, Maria, MD Reappointment Effective:	Cardiology May 20, 2012 thru May 19, 2014	Voluntary Physician

Item VIII(A) – March 20, 2012

CCHHS Quality and Patient Safety Committee Meeting

Page 1 of 4

Page 102 of 105

**CCHHS
APPROVED**

**BY THE QUALITY AND PATIENT SAFETY COMMITTEE
ON MARCH 20, 2012**

A handwritten signature in black ink, appearing to be "S. Serrato-Buevento".

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications (continued)

Department of Psychiatry

Matek, Deborah, MD	Child Adolescent/CHS	Active Physician
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Department of Radiology

Bugeag, Ionut, MD	Breast Imaging	Active Physician
Reappointment Effective:	April 19, 2012 thru April 18, 2014	

Department of Surgery

Bonomo, Steven, MD	General Surgery	Active Physician
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Dwarakanthan, Surendar, MD	Ophthalmology	Active Physician
Reappointment Effective:	May 16, 2012 thru May 15, 2014	

Mason, Terry, MD	Urology	Active Physician
Reappointment Effective:	May 20, 2012 thru May 19, 2014	

Non-Medical Staff Renewal of Privileges

Anderson, Karla, PsyD	Psychiatry/Psychology	Clinical Psychologist
Reappointment Effective:	March 23, 2012 thru March 22, 2014	

Brenzinger, Mark, PsyD	Psychiatry/Psychology	Clinical Psychologist
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Buenaventura, Brian J., CRNA	Anesthesiology	Nurse Anesthetist
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Cafferty, Breedge M., CRNA	Anesthesiology	Nurse Anesthetist
Reappointment Effective:	May 20, 2012 thru May 19, 2014	

Chavez, Ariel O., PA-C	Medicine/Hematology/Oncology	Physician Assistant
With Lad, Thomas E., MD		
Alternate Rosen, Fred R., MD		
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Garlewski, Thaddeus, PhD	Psychiatry/Psychology	Clinical Psychologist
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Lewis, Gregory, PsyD	Psychiatry/Psychology	Clinical Psychologist
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Nunez, Pierre, PhD	Psychiatry/Psychology	Clinical Psychologist
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

Reyes, Margaret E., CNP	Family Practice	Nurse Practitioner
With Grivois-Shah, Ravi P., MD		
Reappointment Effective:	March 20, 2012 thru March 19, 2014	

John H. Stroger, Jr. Hospital of Cook County

Non-Medical Staff Renewal of Privileges (continued)

Soro, Nancy, PhD Reappointment Effective:	Psychiatry/Psychology March 20, 2012 thru March 19, 2014	Clinical Psychologist
Yapondjian, Maria, PsyD Reappointment Effective:	Psychiatry/Psychology March 20, 2012 thru March 19, 2014	Clinical Psychologist

Non-Medical Staff Additional Clinical Privileges

Barnes, Brenda L., PA-C With Leekha, Deepak, MD Alternate Shah, Sejal, MD	Medicine/General Medicine	Physician Assistant
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Provident Hospital of Cook County



Medical Staff Appointment, Reappointments and Non-Medical Staff Action Items, subject to approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPLICATIONS

Telemedicine Privilege Requests

Iqbal, Nasir, MD	Radiology/Teleradiology
Appointment Effective:	March 20, 2012 thru March 19, 2014

REAPPOINTMENT APPLICATIONS

Department of Internal Medicine

Cook, Edwin J., MD	Nephrology	Consulting Physician
Reappointment Effective:	April 18, 2012 thru April 17, 2014	

Fegan, Claudia, MD	Internal Medicine	Affiliate Physician
Reappointment Effective:	March 22, 2012 thru March 21, 2014	

Fisher Sr., Thomas L., MD	Dermatology	Consulting Physician
Reappointment Effective:	March 28, 2012 thru March 27, 2014	

Khan, Abdul K., MD	Cardiology	Consulting Physician
Reappointment Effective:	April 18, 2012 thru April 17, 2014	

Mullane, Michael R., MD	Hematology/Oncology	Affiliate Physician
Reappointment Effective:	April 20, 2012 thru December 30, 2013	